

Centers for Medicare & Medicaid Services: President's FY2015 Budget

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Summary

Federal law requires the President to submit an annual budget to Congress no later than the first Monday in February. The budget informs Congress of the President's overall federal fiscal policy based on proposed spending levels, revenues, and deficit (or surplus) levels. The budget request lays out the President's relative priorities for federal programs, such as how much should be spent on defense, education, health, and other federal programs. The President's budget may also include legislative proposals for spending and tax policy changes. While the President is not required to propose legislative changes for those parts of the budget that are governed by permanent law (i.e., mandatory spending), such changes are generally included in the budget. President Obama submitted his FY2015 budget to Congress on March 4, 2014.

The Centers for Medicare & Medicaid Services (CMS) is the division of the Department of Health & Human Services (HHS) that is responsible for administering Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP), and the private health insurance programs. CMS is the largest purchaser of health care in the United States, with expenditures from CMS programs accounting for roughly one-third of the nation's health expenditures. In FY2015, it is estimated that more than one in three Americans will be provided coverage through Medicare, Medicaid, and CHIP. CMS is also responsible for administering the private health insurance programs established in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended).

The CMS budget includes a mixture of both mandatory and discretionary spending. However, the vast majority of the CMS budget is mandatory spending, such as Medicare benefits and grants to states for Medicaid.

For budgetary purposes, CMS is divided into the following sections: Medicare, Medicaid, program integrity, CHIP, state grants and demonstrations, private health insurance protections and programs, the Center for Medicare and Medicaid Innovation, and program management. The President's FY2015 budget contains a number of legislative proposals that would affect the CMS budget. Some are program expansions, and others are designed to reduce federal spending.

The President's proposed budget for CMS would be \$897.4 billion in net mandatory and discretionary outlays for FY2015. This would be an increase of \$53.8 billion, or 6.4%, over the net outlays for FY2014. This estimate includes the cost of the Medicare physician payment adjustment (\$13.7 billion), the net cost of legislative proposals (\$2.5 billion), and the estimated savings from program integrity investments (-\$0.2 billion).

This report summarizes the President's budget estimates for each section of the CMS budget. Then, for each legislative proposal included in the President's budget, this report provides a description of current law and the President's proposal. The explanations of the President's legislative proposals are grouped by the following program areas: Medicare, Medicaid, program integrity, CHIP, state grants and demonstrations, private health insurance programs, and program management. A table summarizing the estimated costs or savings for each legislative proposal is at the end of each of these sections.

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Introduction

Federal law requires the President to submit an annual budget to Congress no later than the first Monday in February.¹ The budget informs Congress of the President's overall federal fiscal policy based on proposed spending levels, revenues, and deficit (or surplus) levels. The budget request lays out the President's relative priorities for federal programs, such as how much should be spent on defense, education, health, and other federal programs. The President's budget may also include legislative proposals for spending and tax policy changes. While the President is not required to propose legislative changes for those parts of the budget that are governed by permanent law (i.e., mandatory spending), such changes are generally included in the budget. President Obama submitted his FY2015 budget to Congress on March 4, 2014.

The Centers for Medicare & Medicaid Services (CMS) is the division of the Department of Health & Human Services (HHS) that is responsible for administering Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), and the private health insurance programs. CMS is the largest purchaser of health care in the United States with Medicare and federal Medicaid expenditures accounting for 29.0% of the total national health expenditures in 2012.² In FY2015, CMS estimates 123 million individuals will be covered by Medicare, Medicaid, or CHIP, which is more than one in three Americans.

This report summarizes the President's budget estimates for each section of the CMS budget. Then, for each legislative proposal included in the President's budget, this report provides a description of current law and the President's proposal. The explanations of the President's legislative proposals are grouped by the following program areas: Medicare, Medicaid, program integrity, CHIP, state grants and demonstrations, private health insurance programs, and program management. At the end of each of these sections, there is a table summarizing the estimated costs or savings for each legislative proposal.

Basic Budget Terminology

Budget Authority: When Congress appropriates money, it provides budget authority, that is, authority to enter into obligations. Budget authority also may be provided in legislation that does not go through the appropriations process (i.e., mandatory or direct spending legislation).

Discretionary Spending: Refers to budget authority and outlays that are provided in and controlled by appropriation acts.

Mandatory Spending: Refers to budget authority that is provided outside of the annual appropriations process (i.e., through authorizing legislation) and the outlays that result from such budget authority.

Outlays: Occur when obligations are liquidated, primarily through the issuance of checks, electronic fund transfers, or the disbursement of cash.

Offsetting Receipts: Certain receipts of the federal government are accounted for as "offsets" against outlays rather than as revenues, such as Medicare Part B and Part D premiums.

Note: For more information about the federal budget process, see CRS Report 98-721, *Introduction to the Federal Budget Process*, coordinated by Bill Heniff Jr.

¹ 31 U.S.C. 1105(a).

² Centers for Medicare & Medicaid Services, National Health Expenditures Data.

Budget Summary

The CMS budget includes a mixture of both mandatory and discretionary spending. However, a vast majority of the CMS budget is mandatory spending, such as Medicare benefits and grants to states for Medicaid.

The President's budget estimates that under current law CMS mandatory and discretionary net outlays would amount to \$881.2 billion in FY2015.³ This is an increase of \$44.4 billion, or 5.3%, over the estimated net outlays for FY2014.⁴

The President's FY2015 budget increases the baseline for Medicare spending by assuming no reduction in Medicare payments for physician services, relative to current levels, from FY2015 through FY2024, in contrast to the sustainable growth rate formula (SGR) under current law, which calls for significantly lower physician payments during this 10-year period. The President's budget estimates this adjustment will increase CMS's net outlays by \$6.2 billion in FY2014 and \$13.7 billion in FY2015. With this adjustment, CMS's total net outlays are estimated to be \$894.9 billion in FY2015.

The President's FY2015 budget proposes to make a number of legislative changes to Medicare, Medicaid, program integrity, CHIP, state grants and demonstrations, private health insurance programs, and program management. The President's budget estimates that if these legislative proposals were implemented, CMS's total net outlays would increase by \$0.5 billion in FY2014 and increase by a net of \$3.0 billion in FY2015.

With the Medicare physician payment adjustment, the estimated impact of the legislative proposals, and the estimated savings from program integrity activities (\$0.6 billion), the President's budget estimates CMS's net outlays will be \$897.4 billion in FY2015, which is an increase of \$53.8 billion, or 6.4%, over the net outlays for FY2014.

For budgetary purposes, CMS is divided into the following sections: Medicare, Medicaid, program integrity, CHIP, state grants and demonstrations, private health insurance, the Center for Medicare and Medicaid Innovation (CMMI), and program management. The President's budget estimates for each of these budget sections are summarized below, along with a description of each of these sections of the CMS budget.

Medicare

Medicare is a federal program that pays for covered health care services of qualified beneficiaries. It was established in 1965 under Title XVIII of the Social Security Act as a federal entitlement program to provide health insurance to individuals 65 and older. Over the years, Medicare has been expanded to include individuals under 65 who cannot work because they have a medical condition that is expected to last at least one year or result in death, have end-stage renal disease (permanent kidney failure requiring dialysis or transplant), or have amyotrophic

³ The figures in this document are taken from the following two documents: Department of Health and Human Services, *Fiscal Year 2015 Budget in Brief: Strengthening Health and Opportunity for All Americans* (<http://www.hhs.gov/budget/fy2015/fy-2015-budget-in-brief.pdf>) and Department of Health and Human Services' Centers for Medicare & Medicaid Services, *Fiscal Year 2015 Justification of Estimates for Appropriations Committees* (<http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2015-CJ-Final.pdf>).

⁴ The President's budget changes the ongoing sequestration of spending order under the Budget Control Act of 2011 (P.L. 112-25). The proposed budget eliminates the mandatory sequester starting in FY2015 and reduces the size of the discretionary sequester for FY2016 and subsequent years.

lateral sclerosis (ALS, Lou Gehrig's disease). Medicare, which consists of four parts (A-D), covers hospitalizations, physician services, prescription drugs, skilled nursing facility care, home health visits, and hospice care, among other services.⁵

The President's FY2015 budget estimates that under current law Medicare outlays net of offsetting receipts will be \$521.6 billion in FY2015 (see **Table 1**). The President's budget makes adjustments to the baseline assuming congressional action preventing a reduction in Medicare physician payments,⁶ which increases the FY2015 baseline outlays net offsetting receipts by \$13.7 billion. The budget includes a number of legislative proposals for Medicare. If implemented, these legislative proposals are estimated to decrease Medicare outlays by \$2.8 billion in FY2015 and a cumulative \$407.2 billion over the next 10 years.⁷ With the baseline adjustments and the estimated impact of the legislative proposals, the President's budget estimates that Medicare's total net mandatory and discretionary outlays for FY2015 will be \$532.9 billion, which is an increase of \$13.8 billion, or 2.7%, over the estimated net outlays for FY2014.

The "Medicare Legislative Proposals" section below includes an explanation of current law and a description of each legislative proposal pertaining to the Medicare program. At the end of the section, there is a table summarizing the costs or savings for each of the President's legislative proposals.

Table 1. President's FY2015 Budget for the Centers for Medicare & Medicaid Services
(dollars in billions)

	FY2014-FY2015				
	FY2013	FY2014	FY2015	\$ Change	% Change
Medicare					
Current Law	\$497.8	\$512.5	\$521.6	\$9.1	1.8%
Adjustments	0.0	6.2	13.7		
Legislative Proposals ^a	0.0	0.4	-2.4		
Subtotal	497.8	519.0	532.9	13.8	2.7%
Medicaid					
Current Law	265.4	308.4	331.4	23.0	7.5%
Legislative Proposals	0.0	0.2	4.5		
Subtotal	265.4	308.6	336.0	27.3	8.9%
State Children's Health Insurance Program					
Current Law ^b	9.5	10.3	10.6	0.3	3.1%

⁵ For more information about the Medicare program, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga.

⁶ For more information about Medicare physician payments, see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by Jim Hahn.

⁷ In the table, the \$2.4 billion in savings in the Medicare legislative proposals row includes \$2.8 billion in savings from Medicare legislative proposals net of premiums and offsetting receipts, in addition to the cost of \$0.4 million in Health Care Fraud and Abuse Control investments.

	FY2013	FY2014	FY2015	FY2014-FY2015	
				\$ Change	% Change
Legislative Proposals	0.0	0.0	0.0 ^c		
Subtotal	9.5	10.3	10.6	0.3	3.2%
State Grants and Demonstrations					
Current Law	0.5	0.7	0.7	-0.1	-10.1%
Legislative Proposals	0.0	0.0	0.0 ^d		
Subtotal	0.5	0.7	0.7	-0.1	-6.8%
Private Health Insurance Programs					
Current Law	3.5	3.8	15.5	11.7	306.6%
Legislative Proposals	0.0	0.0	0.0		
Subtotal	3.5	3.8	15.5	11.7	306.6%
Centers Medicare & Medicaid Innovation					
Current Law	0.7	1.1	1.4	0.4	37.0%
Savings from Program Integrity ^e	0.0	0.0	-0.2	-0.2	
Total Net Outlays	\$777.3	\$843.6	\$897.4	\$53.8	6.4%

Source: Table created by CRS based on data from the Department of Health and Human Services, *Fiscal Year 2015 Budget in Brief: Strengthening Health and Opportunity for All Americans*, March 2014.

Notes: Funding for program management activities is built into this table. Totals may not add due to rounding.

- a. The \$2.4 billion in savings includes \$2.8 billion in savings from Medicare legislative proposals net of premiums and offsetting receipts, in addition to the cost of \$0.4 billion for program management legislative proposals and \$0.4 billion in Health Care Fraud and Abuse Control investments.
- b. Includes Child Enrollment Contingency Fund.
- c. Costs of \$10 million.
- d. Costs of \$25 million.
- e. Includes Health Care Fraud and Abuse Control investments and non-PAYGO scorecard savings from additional investments in Health Care Fraud and Abuse Control and Social Security disability reviews, above savings already assumed in current law.

Medicaid

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term services and supports. Medicaid is jointly funded by the federal government and the states. The federal government pays a share of each state's Medicaid costs, and states must contribute the remaining portion in order to qualify for federal funds.⁸

Participation in Medicaid is voluntary for states, though all states, the District of Columbia, and the territories choose to participate. Each state designs and administers its own version of Medicaid under broad federal rules. While states that choose to participate in Medicaid must comply with all federal mandated requirements, state variability is the rule rather than the

⁸ For more information about the Medicaid program, see CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell.

exception in terms of eligibility levels, covered services, and how those services are reimbursed and delivered.

The President's FY2015 budget estimates that under current law Medicaid total net outlays will amount to \$331.4 billion, which is an increase of \$23.0 billion, or 7.5%, over estimated net outlays for FY2014 (see **Table 1**).⁹ The President's budget includes a number of legislative proposals that would impact Medicaid. If these proposals are implemented, the President's budget estimates that total net outlays for Medicaid would increase by \$4.5 billion in FY2015 and decrease by a cumulative \$7.3 billion over the next 10 years.¹⁰ Including the estimated impact of the legislative proposals and savings from program integrity investments, the President's budget estimates FY2015 net outlays for Medicaid will amount to \$336.0 billion, which is an increase of \$27.3 billion, or 8.9%, over the estimated net outlays for FY2014.

The "Medicaid Legislative Proposals" section below includes a brief discussion of current and proposed law for each of the legislative proposals for the Medicaid program. At the end of the section, there is a table summarizing the costs or savings for each of these proposals.

Program Integrity

Title II of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) established the Health Care Fraud and Abuse Control (HCFAC) program to detect, prevent, and combat health care fraud, waste, and abuse. HCFAC has traditionally focused on Medicare fraud, waste, and abuse through activities such as medical review, benefit integrity, and provider audits. In FY2009, discretionary funding was appropriated, which allowed HCFAC to expand its activities to Medicare Advantage and Medicare Part D among other things. In addition, HCFAC mandatory and discretionary funding is used to prevent fraud, waste, and abuse in the Medicaid program.

The budget estimates for the program integrity activities are built into the budget summaries discussed above for Medicare and Medicaid and are not explicitly broken out in **Table 1**. However, when the funding for program integrity activities are broken out, the President's FY2015 budget estimates total budget authority for program integrity activities will amount to \$2.0 billion in FY2015. This is an increase of \$461 million, or 29.6%, over FY2014. Funding for program integrity consists of both mandatory and discretionary funding. In FY2015, the mandatory funding for program integrity activities is estimated to be \$1.7 billion, and the discretionary funding is estimated to be \$0.3 billion.

The "Program Integrity Legislative Proposals" section below includes a description of current and proposed law for each of the program integrity legislative proposals. At the end of the section, there is a table summarizing the costs or savings for each of the President's legislative proposals.

CHIP

The Balanced Budget Act of 1997 (BBA97, P.L. 105-33) established CHIP to provide health insurance coverage to low-income, uninsured children in families with incomes above applicable Medicaid income standards. Authorization and funding for CHIP has been extended a number of times, and most recently, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as

⁹ The federal Medicaid budget consists of funding for benefits and state administration. According to the President's budget, under current law, outlays for benefits are expected to increase by \$22.8 billion, or 7.9%, in FY2014, and outlays for state administration are estimated to increase by \$0.2 billion, or 1.1%, in FY2014.

¹⁰ These figures include the impact of program integrity proposals, which are estimated to result in savings to the Medicaid program of \$19 million in FY2015 and \$620 million over the next 10 years.

amended) extended federal funding for CHIP through FY2015. CHIP is jointly funded by the federal government and the states, and federal CHIP funding is capped on a state-by-state basis according to annual allotments.

The President's FY2015 budget estimates that under current law CHIP's total outlays will amount to \$10.6 billion, which is an increase of \$0.3 billion, or 3.1%, over the estimated outlays for FY2014 (see **Table 1**).¹¹ The President's budget includes a couple of legislative proposals that would impact CHIP, and if these proposals are implemented, the President's budget estimates CHIP outlays would increase by \$10 million in FY2015 and \$345 million over the next 10 years.

The "CHIP Legislative Proposals" section below includes a brief discussion of current and proposed law for each of the legislative proposals impacting CHIP. At the end of the section, there is a table summarizing the costs or savings for each of these proposals.

State Grants and Demonstrations

The state grants and demonstrations portion of the budget funds a diverse set of grant programs and other activities. The grants and activities funded through this portion of the budget include the following: Money Follows the Person Demonstration, Medicaid Integrity Program, incentives for prevention of chronic diseases in Medicaid, CHIP Outreach and Enrollment Grants, Medicaid Emergency Psychiatric Demonstration, and emergency services for undocumented aliens.

The President's budget estimates that under current law FY2015 total outlays for state grants and demonstrations will amount to \$0.7 billion, which is a decrease of \$76 million, or -10.1%, from FY2014 (see **Table 1**). The President's budget includes a few legislative proposals impacting the budget for state grants and demonstrations that are estimated to increase outlays by \$25 million in FY2015 and \$776 million over the next 10 years.

The "State Grants and Demonstrations Proposals" section below includes a brief discussion of current and proposed law for each of the legislative proposals impacting state grants and demonstrations. At the end of the section, there is a table summarizing the costs or savings for each of these proposals.

Private Health Insurance Programs

The ACA includes reforms that focus on restructuring the private health insurance market by creating new programs (e.g., health insurance exchanges) and by imposing requirements on private health insurance plans.¹² The Center for Consumer Information and Insurance Oversight (CCIIO) within CMS is charged with helping implement the provisions of the ACA related to the private health insurance programs.

¹¹ The federal CHIP budget consists of outlays for the state allotments and the Child Enrollment Contingency Fund. The Child Enrollment Contingency Fund was added to CHIP in order to prevent states from experiencing shortfalls of federal CHIP funds. This fund receives an appropriation separate from the national CHIP allotment amounts. Direct payments from the Contingency Fund can be made to shortfall states for the federal share of expenditures for CHIP children above a target enrollment level. Payments from the Contingency Fund cannot exceed 20% of that year's national allotment amount and are to be reduced proportionally if necessary. The President's budget estimates outlays for benefits and state administration will increase by \$322 million, or 3.1%, from FY2014 to FY2015, and the Child Enrollment Contingency Fund outlays are estimated to remain level at \$100 million from FY2014 to FY2015.

¹² For more information about the private health insurance protections and programs, see CRS Report R43048, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and CRS Report R42069, *Private Health Insurance Market Reforms in the Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

The President's budget estimates that under current law FY2015 total outlays for the private health insurance programs will amount to \$15.5 billion, which is an increase of \$11.7 billion, or 306.6%, from FY2014 (see **Table 1**). Most of this increase (\$10.0 billion) is attributable to the Transitional Reinsurance Program, and the Risk Adjustment Program will increase the budget for the private health insurance programs by \$3.4 billion.

These increases are offset by the Pre-Existing Conditions Insurance Program ending in FY2014, which causes the budget for the private health insurance programs to decrease by almost \$1.0 billion from FY2014 to FY2015. Also, funding for the exchange grants to states decreases by \$0.6 billion (or 22.4%) from FY2014 to FY2015.

The President's budget includes one legislative proposal that would impact the private health insurance programs, but the President's budget estimates this proposal will not have a budgetary impact. The "Private Health Insurance Programs Proposals" section below includes a description of current and proposed law for the President's legislative proposal.

Centers for Medicare & Medicaid Innovation (CMMI)

CMMI was established by Section 3021 of the ACA and is tasked with testing innovative health care payment and delivery models with the potential to improve quality of care and reduce Medicare and Medicaid expenditures. The ACA appropriated \$10 billion to support CMMI activities from FY2011 through FY2019. CMMI initiatives include Partnership for Patients, Health Care Innovation Awards, bundled payments, Accountable Care Organizations (ACOs), the Federally-Qualified Health Center Advanced Primary Care Practice demonstration, the comprehensive primary care initiative, and the Strong Start initiative.

The President's budget estimates that under current law FY2015 total outlays for CMMI will amount to \$1.4 billion, which is an increase of \$0.4 billion, or 37.0%, from FY2014 (see **Table 1**). The President's budget does not include any legislative proposals impacting CMMI.

Program Management

The program management portion of the CMS budget includes funding for the administration of Medicare, Medicaid, CHIP, and other CMS activities. The budget estimates for the program management activities are built into the budget summaries discussed above and are not explicitly broken out in **Table 1**. However, when the funding for program management activities are broken out, the President's budget estimates that under current law the FY2015 budget for program management activities (including both discretionary budget authority and mandatory spending) will be \$6.5 billion,¹³ which is \$1.2 billion (or 21.9%) more than the FY2014 level.

Funding for program management consists of both discretionary and mandatory funding. The discretionary funding for program management activities is estimated to be \$4.2 billion in FY2015, which is an increase of \$0.2 billion, or 5.7%, over FY2014 funding. The discretionary funding for program management activities is broken into five different budget lines—program operations, federal administration, survey and certification, research, and state high risk pools.

¹³ The President's budget estimate for CMS's program management activities includes an adjustment for reimbursable administration, which is offsetting collections from non-federal sources that are estimated to be \$2.1 billion in FY2015. This reimbursable administration adjustment includes health insurance exchanges, risk adjustments, Clinical Laboratory Improvement Amendments of 1988, sale of research data, coordination of benefits for the Medicare prescription drug program, Medicare Advantage/prescription drug program education campaign, recovery audit contractors, and provider enrollment fees.

In FY2015, under current law, the mandatory funding for program management activities is estimated to be \$199 million, which is a \$64 million decrease from the FY2014 funding. The President's budget includes a few legislative proposals that would impact program management activities. If these proposals are implemented, the President's budget estimates that total program level funding for program management activities would increase by \$36 million in FY2015 and \$500 million over the next 10 years. The legislative proposals impacting program management are discussed in the "Program Management Proposals" section of the CMS budget.

Including the impact of the legislative proposals, the President's budget estimates total program level funding for program management activities would amount to \$6.9 billion in FY2015, which is an increase of \$1.6 billion, or 30.2%, over FY2014. When risk corridor charges are included, the estimated program level funding for program management activities increases to \$12.4 billion in FY2015.

Legislative Proposals

The President's FY2015 budget contains a number of proposals that would impact the CMS budget. Some are program expansions, and others are designed to reduce federal spending. For each proposal, this report provides a description of current law and the President's proposal. This report groups these legislative proposals by program areas: Medicare, Medicaid, program integrity, CHIP, state grants and demonstrations, private health insurance programs, and program management. At the end of each of these sections, there is a table summarizing the costs or savings for each legislative proposal as estimated by the Administration,¹⁴ and the tables classify each proposal as new, modified from the President's FY2014 budget, or repeated from the President's FY2014 budget.¹⁵

Common Acronyms for Public Laws

ACA: The Patient Protection and Affordable Care Act (ACA as amended, P.L. 111-148)

ARRA: The American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5)

ATRA: The American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240)

BBA: The Bipartisan Budget Act (BBA; P.L. 113-67)

BBA97: The Balanced Budget Act of 1997 (BBA 1997, P.L. 105-33)

BIPA: The Benefits Improvement and Protection Act of 2000 (BIPA, incorporated into the Consolidated Appropriations Act of 2001, P.L. 106-554)

CHIPRA: Children's Health Insurance Program Reauthorization Act (CHIPRA; P.L. 111-3)

DRA: The Deficit Reduction Act of 2005 (DRA; P.L. 109-171)

MCTRJCA: Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96)

MIPPA: Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275)

MMA: The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173)

MMSEA: The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173)

¹⁴ The Congressional Budget Office estimated the costs and savings for the legislative proposals in the President's FY2015 budget impacting the programs in CMS. The CBO analysis provides separate estimates for most but not all of the proposals discussed in this report, and CBO's estimate can be quite different from that of the Administration. (Congressional Budget Office, *Estimated Effects on Direct Spending and Revenues for Health Care Programs of Proposals in the President's FY2015 Budget*, April 17, 2014, http://www.cbo.gov/sites/default/files/cbofiles/attachments/45250-Health_Programs_Proposals.pdf.)

¹⁵ Legislative proposals classified as "repeated" might have different start dates than the FY2014 proposal due to the start date from the FY2014 budget lapsing or legislation having been enacted that impacted the start date from FY2014 budget.

Medicare Legislative Proposals

Medicare Part A

Reduce Medicare Coverage of Bad Debts

Current Law

Medicare reimburses providers for beneficiaries' unpaid coinsurance and deductible amounts after reasonable collection efforts. Historically, Medicare has reimbursed 100% of these bad debts. BBA97 had scheduled bad debt in acute care hospitals to be reduced from 100% reimbursement to 75% reimbursement in FY1998, to 60% reimbursement in FY1999, and to 55% reimbursement in subsequent years; however, BIPA froze the reduction at 70% reimbursement in FY2001 and for subsequent years. DRA reduced the payment amount for Medicare-allowable skilled nursing facility (SNF) bad debt from 100% to 70%, except for the bad debt attributable to beneficiaries eligible for both Medicare and Medicaid (i.e., dual eligibles), effective for cost reporting periods beginning on or after October 1, 2005. For other Medicare providers, allowable beneficiary bad debt had been reimbursed at 100%. Other Medicare providers that receive bad debt reimbursement are critical access hospitals, rural health clinics, federally qualified health clinics, community mental health clinics, dialysis facilities, health maintenance organizations reimbursed on a cost basis, competitive medical plans, and health care prepayment plans. The MCTRJCA reduced Medicare bad debt reimbursement to 65% for all providers. Providers who were reimbursed at 70% receive 65% bad debt reimbursement beginning in FY2013. Other providers who were reimbursed at 100% of bad debt are reimbursed at 88% in FY2013 and are reimbursed at 76% in FY2014 and 65% in FY2015 and subsequent years.

President's Proposal

The President's budget would reduce bad debt reimbursement to 25%. The scheduled reduction would be phased-in over three years beginning in FY2015 for all providers that receive bad debt payments. *This proposal was included in the President's FY2014 budget proposal.*

Better Align Graduate Medical Education Payments with Patient Care Costs

Current Law

Medicare pays hospitals with approved medical residency programs an additional amount to support the higher costs of patient care associated with training physicians. These indirect medical education (IME) payments are calculated as a percentage increase to Medicare's inpatient payment rates. The IME payments vary depending on the size of the hospital's teaching program (subject to Medicare's cap) as measured by the hospital's ratio of residents to hospital beds. Generally, teaching hospitals receive a 5.5% increase in IME payments for every 10% increase in their resident-to-bed ratio. The Medicare Payment Advisory Commission (MedPAC) has found that less than half of the IME payments can be empirically justified. In its June 2010 report, MedPAC recommended that Medicare's funding of graduate medical education be changed to support necessary workforce skills and that the Secretary of HHS set standards for receiving such funds.

President's Proposal

The President's budget would reduce IME funding by a total of 10%, starting in FY2015. The Secretary would be given the authority to set standards for teaching hospitals to encourage the training of primary care residents and develop necessary workforce skills.¹⁶ *This proposal was included in the President's FY2014 budget proposal.*

Reduce Critical Access Hospital Payments to 100% of Costs

Current Law

As established by BBA97, critical access hospitals (CAHs) are limited-service rural facilities that meet certain distance criteria or have been designated as a necessary provider, offer 24-hour emergency care, have no more than 25 acute care inpatient beds, and have no more than a 96-hour average length of stay.

Generally, CAHs receive enhanced cost-based Medicare payments, rather than payments paid to acute care hospitals under the Medicare's prospective payment systems (PPS). Since FY2004, CAHs receive 101% of reasonable, cost-based reimbursement for inpatient care, outpatient care, ambulance services, and skilled nursing facility (SNF) care provided in swing beds to Medicare beneficiaries. Prior to this date, CAHs received Medicare payment based on 100% of reasonable costs for these services.

President's Proposal

The President's budget would reduce Medicare's reimbursement to CAHs to 100% of reasonable costs, beginning in FY2015. *This proposal was included in the President's FY2014 budget proposal.*

Prohibit Critical Access Hospital Designation for Facilities that are less than 10 Miles from the Nearest Hospital

Current Law

In order to be certified as a CAH, a rural entity must meet certain distance criteria or have been designated as a necessary provider by the state. Under federal distance standards, a CAH must meet one of the following criteria: (1) be located 35 miles from another hospital or (2) be located 15 miles from another hospital in areas with mountainous terrain or with only secondary roads. Until January 1, 2006, states could waive these federal mileage requirements for those entities determined to be necessary providers. Existing necessary providers maintained their status as CAHs.

President's Proposal

The President's budget would rescind state's ability to waive federal mileage requirements for entities less than 10 miles from another hospital or CAH, thus eliminating their Medicare cost-

¹⁶ The President's budget would reinvest \$530 million in the mandatory savings from the proposal to better align graduate medical education payments with patient care costs in workforce development, via a new targeted grant program administered by the Health Resources and Services Administration (HRSA) that would fund teaching hospitals, children's hospitals, and community-based consortia of teaching hospitals and other entities that focus on ambulatory and preventative care. This HRSA proposal was *not* included in the President's FY2014 Budget.

based payments beginning in FY2015. *This proposal was included in the President's FY2014 budget proposal.*

Adjust Payment Updates for Certain Post-Acute Care Providers

Current Law

MedPAC has found that Medicare payments generally exceed providers' costs for post-acute services. Each year, MedPAC makes recommendations for provider payment increases for the next fiscal or rate year. In its March 2015 report, MedPAC recommended that the Medicare payment updates for SNFs, inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs), and home health agencies (HHAs) be eliminated for the upcoming year. The ACA amended the annual update policy for these post-acute providers to include an adjustment to account for economy-wide productivity increases for cost savings.¹⁷ The productivity adjustment for SNFs, IRFs, and LTCHs was implemented on October 1, 2011. The productivity adjustment for HHAs will be implemented on January 1, 2015. The annual updates for IRFs, HHAs, and LTCHs are subject to other reductions as well. The amount and the timing of such reductions vary by provider. Every post-acute provider may have an update less than 0.0 which would result in a lower payment rate than in the preceding year.

President's Proposal

The President's budget would implement additional update reductions for IRFs, LTCHs, and HHAs of 1.1 percentage points from FY2015 through FY2024. Payment updates for these providers would not drop below 0.0 due to the 1.1 percentage point reduction. The annual update for SNFs would be set at -2.5% update in FY2015 declining to 0.97% update in FY2022. *This proposal is a modification of a legislative proposal from the President's FY2014 Budget.*

Implement Bundled Payment for Post-Acute Care Providers

Current Law

Post-acute care services primarily include nursing and rehabilitation services following a beneficiary's inpatient hospital stay. These services can be offered in institutional settings, such as LTCHs, IRFs, SNFs, as well as in community-settings by HHAs. Use of post-acute care services is dramatically different across states. The Institute of Medicine (IOM) has noted that geographic variation in overall Medicare spending is heavily influenced by the use of post-acute care services, particularly SNFs and home health services. To encourage a more efficient use of post-acute care and improve care coordination, MedPAC's June 2008 report suggested a single predetermined payment for an episode of care that includes the beneficiary's inpatient hospital stay as well as physician services, post-acute care services, and any hospital readmissions. Additionally, CMS has a Bundled Payment for Care Improvements (BPCI) Initiative to test different bundling payment models. In Model 2 of the BPCI, participants in the initiative will manage a beneficiary's episode (either 30, 60, or 90 days) that includes the acute-care hospital services, physician services, and post-acute care services. Participants that achieve a reduction in

¹⁷ Productivity, in general, is a measure of output relative to the amount of work required to produce it. The ACA adjusts Medicare's annual payment updates to account for economy-wide productivity increases, thus providing additional cost savings to the Medicare program.

episode spending when compared to a pre-determined spending benchmark will be allowed to share in the savings.

President's Proposal

The President's budget would implement a bundled payment for post-acute care providers (LTCHs, IRFs, SNFs, and HHAs) beginning in FY2019. The bundled payment would be based on patient characteristics and other factors and be set to reduce Medicare expenditures by 2.85% by FY2021. Payments would be bundled for at least half of the total payments for post-acute care providers, but little detail was provided as to how this would work. *This proposal was included in the President's FY2014 Budget.*

Encourage Appropriate Use of Inpatient Rehabilitation Facilities

Current Law

IRFs are either freestanding hospitals or distinct units of other hospitals that are exempt from Medicare's inpatient prospective payment system (IPPS), which is used to pay acute care, general hospitals. Until recently, the Medicare statute gave the Secretary the discretion to establish the criteria that facilities must meet in order to be considered IRFs. Starting October 1, 1983, CMS has required that a facility must treat a certain proportion of patients with specified medical conditions in order to qualify as an IRF and receive higher Medicare payments. IRFs were required to meet the "75 percent rule," which determined whether a hospital or unit of a hospital qualified for the higher IRF payment rates or was paid as an acute care hospital. According to the rule, at least 75% of a facility's total inpatient population must be diagnosed with one of 13 pre-established medical conditions for that facility to be classified as an IRF. This minimum percentage is known as the compliance threshold. The rule was suspended temporarily and reissued in 2004 with a revised set of qualifying conditions and a transition period for the compliance threshold as follows: 50% from July 1, 2004, and before July 1, 2005; 60% from July 1, 2005, and before July 1, 2006; 65% from July 1, 2006, and before July 1, 2007, and at 75% from July 1, 2007, and thereafter. During the transition period, secondary conditions (comorbidities) were to be considered as qualifying conditions. The DRA extended the 60% threshold an additional year beginning on July 1, 2006. As established by MMSEA, starting July 1, 2007, the IRF compliance threshold is set at 60% and comorbidities are included as qualifying conditions.

President's Proposal

The President's budget would reinstitute the 75% threshold, starting in FY2015. *This proposal was included in the President's FY2014 budget proposal.*

Adjust Skilled Nursing Facilities Payments to Reduce Hospital Readmissions

Current Law

As established by the ACA, acute care hospitals with relatively high readmission rates are subject to penalties starting in FY2013. The penalties are capped at 1% of the Medicare payment in FY2013, at 2% in FY2014, and at 3% in FY2015 and beyond. SNFs with high readmission rates are not subject to such penalties. In its March 2012 report, MedPAC recommended that Congress reduce Medicare payments to SNFs with relatively high risk-adjusted rehospitalization rates to improve care coordination across different health care settings. According to MedPAC, in

FY2011, 19% of beneficiaries receiving SNF care are rehospitalized for potentially avoidable conditions within 30 days of their SNF stay.

President's Proposal

The President's budget would reduce payments to SNFs with high rates of preventable hospital readmissions by up to 3% beginning in FY2018. *This proposal was included in the President's FY2014 Budget.*¹⁸

Equalize Payments for Certain Conditions Treated in Inpatient Rehabilitation Facilities and Skilled Nursing Facilities

Current Law

Patients receiving treatment for certain conditions such as hip and knee replacements can receive rehabilitative care in a variety of post-acute care settings, including SNFs and IRFs. Generally, care provided in an IRF is paid at a higher rate than care provided in an SNF.

President's Proposal

The President's budget would adjust reimbursement rates in the different post-acute care settings for certain overlapping conditions treated in multiple settings. Beginning in FY2015, the proposal would limit payment differentials for three conditions involving hips and knees, pulmonary conditions, and additional conditions the Secretary considers applicable. IRFs that provide intensive rehabilitation services to patients with relatively uncomplicated conditions would be paid as SNFs. *This proposal was included in the President's FY2014 Budget.*

Clarify the Medicare DSH Statute

Current Law

Prior to FY2015, qualifying acute care hospitals received disproportionate share hospital (DSH) funds through an adjustment within the IPPS. Generally, DSH hospitals received the additional payments based on their DSH patient percentage and the applicable formula established in statute. A few urban acute care hospitals receive DSH payments under an alternative formula. The Medicare DSH payment adjustment has been the subject of substantial litigation.

In FY2015, Medicare DSH funding to acute care hospitals changed. Qualifying IPPS hospitals that get Medicare DSH funding receive 25% of the amount of DSH funds established by the existing DSH formula. The remaining DSH funds, reduced by the amount of the change in the uninsured from the enactment of ACA and other ACA adjustments, are distributed to these

¹⁸ The President's FY2015 budget was released prior to the passage of the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93). At the time the President's proposal was developed, Medicare payments for SNF care were not adjusted based on the percentage of beneficiaries in an SNF who were admitted to the hospital; however, PAMA partially implemented the President's proposal to adjust SNF payments to reduce hospital admissions. PAMA included a provision to implement a Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program in FY2019 that adjusts Medicare SNF payments on the basis of a performance measure—the rate of SNF beneficiaries readmitted to a hospital over a defined period of time. SNFs will be scored and ranked based on their hospital readmission rate or improvement by lowering their hospital readmission rate. Under the SNF VBP Program, a 2% reduction in the Medicare SNF per diem will be applied to all covered SNF care and a portion of such reduction will provide funding for higher-achieving SNFs. The remaining portion of the 2% will be retained as savings to the Medicare program.

qualifying DSH hospitals based on their share of uncompensated care. In FY2015, CMS is using a hospital's share of DSH patient days to approximate its share of uncompensated care. DSH patient days are those provided to patients who are eligible for Supplemental Security Income (SSI) and entitled to Medicare Part A benefits and those days provided to Medicaid patients.

President's Proposal

The President's budget would clarify that hospital days for beneficiaries who have exhausted their inpatient Medicare Part A benefits and who are enrolled in Medicare Advantage plans under Part C of Medicare are counted as DSH patient days. *This proposal was included in the President's FY2014 budget proposal.*

Medicare Parts A and B

Implement Value-Based Purchasing for Additional Providers

Current Law

Value-based purchasing refers to a CMS initiative that rewards health care providers with incentive payments for the quality of care provided to Medicare beneficiaries, motivated by the intent to reward quality of care and not just quantity of care. Value-based purchasing is an extension of pay-for-reporting programs established for hospitals (initially called the reporting hospital quality data for annual payment update program, now renamed the hospital inpatient quality reporting program) and for physicians (the physician quality reporting system). Additional initiatives consistent with this approach include the development of other adjustments to payments that are value-based, for example, the value-based physician payment modifier.

President's Proposal

The President's budget would require that value-based purchasing programs be implemented, beginning in 2016, for several additional provider types, including SNFs, HHAs, ambulatory surgical centers, and hospital outpatient departments. The proposal would require that at least 2% of payments be tied to the quality and efficiency of care. *This proposal was not included in the President's FY2014 Budget.*¹⁹

¹⁹ The President's FY2015 budget was released prior to the passage of the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93). At the time the President's proposal was developed, Medicare payments for SNF care were not adjusted based on an SNF's quality or efficiency of care. PAMA partially implemented the President's proposal by expanding value-based purchasing to include SNFs. Under the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program, starting FY2019, SNFs will be eligible to receive a value-based incentive payment, in addition to their usual Medicare per diem reimbursement, or may receive reductions in their per diem reimbursement depending upon their performance ranking. SNFs will be scored and ranked based on their hospital readmission rate or improvement by lowering their hospital readmission rate. Under the SNF VBP, a 2% reduction in the Medicare SNF per diem will be applied to all covered SNF care and a portion of such reduction will provide funding for the value-based incentive payments in the SNF VBP Program. The remaining portion of the 2% will be retained as savings to the Medicare program.

Medicare Part B

Modernize Payments for Clinical Laboratory Services

Current Law

Clinical lab services are paid on the basis of area-wide fee schedules. The fee schedule amounts are updated for each calendar year. There is a nation-wide ceiling on each payment amount set at 74% of the median of all fee schedule amounts for that laboratory test. Generally, the Secretary is required to adjust payments annually by the percentage change in the consumer price index for all urban consumers (CPI-U) together with other adjustments as the Secretary deems appropriate. BBA eliminated updates for 1998 through 2002; MMA eliminated updates for 2004 through 2008; and MIPPA established that, for 2009 through 2013, the update was to be equal to the percentage change in the CPI-U minus 0.5 percentage points (this was amended by the ACA to apply only to 2009-2010). Under current law, as added by the ACA, the annual clinical laboratory fee schedule update for 2011 through 2015 is equivalent to the CPI-U update reduced by (1) a multi-factor productivity adjustment; and (2) 1.75%.

President's Proposal

The President's budget would lower the payment rates under the clinical laboratory fee schedule by 1.75% every year from 2016 through 2023. The proposal would also provide the Secretary with the authority to adjust payment rates under the clinical laboratory fee schedule in a budget-neutral manner. Additionally, the proposal would support policies to encourage electronic reporting of laboratory results. *This proposal was included in the President's FY2014 budget proposal.*²⁰

Modify Reimbursement for Part B Drugs

Current Law

Medicare covers some drugs under Medicare Part B, rather than under Medicare's Part D outpatient prescription drug benefit. Part B drugs are administered "incident to physician services." Providers buy Part B drugs then bill Medicare when they administer the drugs to patients. Physicians and other providers receive two Medicare Part B drug payments (1) for administration of the drug and (2) for purchasing and supplying the drug. Medicare reimburses providers for supplying most Part B drugs based on a formula of 106% of the drug's average sales price (ASP), regardless of providers' drug acquisition cost. Providers negotiate with drug wholesalers and other entities to purchase Part B drugs. Higher volume Part B drug purchasers often can purchase Part B drugs at prices considerably below 106% of ASP, thereby earning profit each time they administer a drug. Lower volume Part B drug purchasers are unable to receive comparable discounts, so they make less profit and may sometimes lose money on Part B drug transactions. The Department of Health and Human Services Office of the Inspector General (OIG) is required to conduct drug price monitoring studies to determine if Part B drug

²⁰ The President's FY2015 budget was released prior to the passage of the Protecting Access to Medicare Act of 2014 (P.L. 113-93), which includes a provision establishing a new mechanism for reimbursing for clinical diagnostic laboratory tests. Starting in January of 2017 (CY2017), the payment rates for clinical diagnostic laboratory tests will be determined using private payor rate information, which is required to be reported by all applicable clinical laboratories. For new tests and for advanced diagnostic tests, payment rates will be based on, respectively (1) crosswalking or gapfilling and (2) actual list charge, and then market rates.

reimbursement based on 106% of ASP exceeds these drugs' widely available market price (WAMP) by 5% or more. When a drug's ASP exceeds WAMP or AMP by 5% or more, the Secretary has authority to substitute for ASP the lesser of either WAMP or 103% of a drug's AMP for Part B drugs. The OIG has found that there was at least a 5% difference between WAMP or AMP and ASP for some portion of Part B drugs. CMS published a final rule that implemented a Part B drug price substitution policy began January 1, 2013.

President's Proposal

Beginning in FY2015, the President's proposed budget would reduce Medicare Part B drug reimbursement from 106% of ASP to 103% of ASP, except when providers' drug acquisition costs were higher than 103% of ASP. When providers' Part B drug acquisition costs exceeded 103% of ASP, then drug manufacturers would be required to pay providers rebates that would reduce the cost to the provider to ASP +3% less a standard overhead fee to be determined by the Secretary. These Part B drug rebates would be excluded from ASP calculations. The Secretary also would have authority to substitute a flat fee in setting Medicare Part B reimbursement for drugs instead of using the percentage-based ASP +3% formula. *This proposal was included in the President's FY2014 Budget.*

Exclude Certain Services from the In-Office Ancillary Services Exception

Current Law

Limitations on physician self-referrals were enacted into law in 1989 under the Ethics in Patient Referrals Act, commonly referred to as the "Stark law."²¹ The Stark law, as amended, and its implementing regulations prohibit certain physician self-referrals for designated health services (DHS)²² that may be paid for by Medicare or Medicaid. In its basic application, the Stark law provides that if a physician (or an immediate family member of a physician) has a financial relationship with an entity, the physician may not make a referral to the entity for the furnishing of DHS for which payment may be made under Medicare or Medicaid. It also provides that the entity may not present (or cause to be presented) a claim to the federal health care program or bill to any individual or entity for DHS furnished pursuant to a prohibited referral. Under one general exception to the Stark law, physicians and group practices are permitted to order and provide certain self-referred DHS in their offices when they meet specific statutory requirements. Although the exception was intended to protect the convenience of patients and to allow patients to receive certain services during their doctor visits, concerns have been raised that it has the potential to promote the overuse of these services.²³

²¹ The Stark law, created as Section 1877 of the Social Security Act and codified at 42 U.S.C. §1395nn, was created by the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, 103 Stat. 2423 (1989). The Stark law was significantly amended by the Omnibus Budget Reconciliation Act of 1993, P.L. 103-66, §13562, 107 Stat. 312 (1993) and is referred to as "Stark II." Regulations for Stark II have been issued by the Centers for Medicare and Medicaid Services (CMS) and are comprehensive. See 42 C.F.R. §411.350 et seq.

²² A list of "designated health services" can be found at 42 U.S.C. §1395nn(h)(6). Services include clinical laboratory services, radiology services, and inpatient and outpatient hospital services.

²³ As pointed out in a Medpac report: "[o]n the one hand, proponents of the [in-office ancillary services] exception argue that it enables physicians to make rapid diagnoses and initiate treatment during a patient's office visit, improves care coordination, and encourages patients to comply with their physicians' diagnostic and treatment recommendations. On the other hand, there is evidence that physician investment in ancillary services leads to higher volume through greater overall capacity and financial incentives for physicians to order additional services. In addition, there are concerns that physician ownership could skew clinical decisions." Medicare Payment Advisory Commission, Report to

President's Proposal

Effective in 2016, the President's budget proposal would exclude radiation therapy, therapy services, advanced imaging, and anatomic pathology services from the in-office ancillary services exception to the Stark law, except when a practice meets certain accountability standards, as defined by the Secretary. *This proposal is a modification of a legislative proposal from the President's FY2014 Budget.*

Modify the Documentation Requirement for Face-to-face Encounters for DME Claims

Current Law

The ACA required that, beginning January 1, 2010, a physician must document that a physician, nurse practitioner, physician assistant, or clinical nurse specialist has had a face-to-face encounter with the patient during the six-month period prior to prescribing durable medical equipment (DME). The Secretary has delayed implementation of this provision until a date to be announced in 2014, in order to give physicians additional time to establish protocols to comply with the requirement.

President's Proposal

This proposal would modify the requirement by allowing certain non-physician practitioners to document the face-to-face encounter. *This proposal was not included in the President's FY2014 Budget.*

Medicare Advantage

Increase the Minimum Medicare Advantage Coding Intensity Adjustment

Current Law

Medicare Advantage (MA or Medicare Part C) is an alternative to original fee-for-service Medicare wherein beneficiaries can receive all Medicare covered benefits (except hospice) through a private health plan. MA plans are paid a per person monthly amount to provide the covered benefits to enrolled beneficiaries. In general, MA payments are risk-adjusted to account for the variation in the cost of providing care. Risk adjustment is designed to compensate plans for the increased cost of treating older and sicker beneficiaries, and thus discourage plans from preferential enrollment of healthier individuals.

The DRA required the Secretary to adjust MA risk scores for patterns of diagnosis coding differences between MA plans and providers under Parts A and B of Medicare for plan payments in 2008, 2009, and 2010. The ACA required the Secretary to conduct further analyses on the differences in coding patterns and adjust for those differences after 2010. Starting in 2014, the ACA specifies minimum coding intensity adjustments, which were subsequently amended by ATRA. In 2014, the coding intensity adjustment is to be at least the value of the adjustment in 2010 plus 1.5 percentage points; for 2015 to 2018, the adjustment is to be not less than the

the Congress, Aligning Incentives in Medicare, June 2010, available at http://www.medpac.gov/documents/Jun10_EntireReport.pdf. See also generally U.S. Gov't Accountability Office, GAO-12-966, Medicare, Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions (2012).

adjustment for the previous year increased by 0.25 percentage points; and starting in 2019, the coding intensity adjustment is to be not less than 5.9%. The minimum required adjustments are to be applied to risk scores until the Secretary implements risk adjustment using MA diagnostic, cost, and use data.

President's Proposal

The President's budget would increase the minimum coding intensity adjustment; starting in 2016, the yearly increase to the minimum coding intensity adjustment would be increased from the current law level of 0.25 percentage points to 0.67 percentage points until the minimum adjustment reached an 8.51% adjustment in 2020 and would be held at that level thereafter. *This proposal is a modification of a legislative proposal from the President's FY2014 Budget.*

Align Employer Group Waiver Plan Payments with Average Medicare Advantage Plan Bids

Current Law

Under the Medicare Advantage program, employers and unions may sponsor Medicare Advantage (MA) plans for their Medicare-eligible employees, retirees, and/or their Medicare-eligible spouses and dependents. The Secretary has statutory authority to waive or modify requirements that may hinder the design, offering, or enrollment in these plans, which are referred to as Employer Group Waiver Plans (EGWPs). Like other MA plans, the EGWPs are paid a per person monthly amount to provide all Medicare covered benefits except hospice, and the method for determining the payment is the same for all plans. Payments to MA plans are based on a comparison of each plan's estimated cost of providing Medicare covered services (a bid) relative to the maximum amount the federal government will pay for providing those services in the plan's service area (a benchmark). If a plan's bid is less than the benchmark, its payment equals its bid plus a rebate. Starting in 2012, the size of the rebate is dependent on plan quality, ranging from 50% to 70% of the difference between the bid and the benchmark. The rebate must be returned to enrollees in the form of either additional benefits, reduced cost sharing, reduced Part B or Part D premiums, or some combination of these. If a plan's bid is equal to or above the benchmark, its payment is the benchmark amount and each enrollee in that plan pays an additional premium, equal to the amount by which the bid exceeds the benchmark. EGWPs tend to bid closer to the benchmark relative to the bids of non-EGWP plans.

President's Proposal

Beginning in payment year 2016, the President's budget would establish payment amounts for EGWPs based on average MA plan bids in each individual market. *This proposal was included in the President's FY2014 Budget.*

Medicare Part D

Align Medicare Drug Payment Policies with Medicaid Policies for Low-Income Beneficiaries

Current Law

Medicare Part D provides coverage of outpatient prescription drugs to beneficiaries who choose to enroll in this optional benefit. About 63% of eligible Medicare beneficiaries are currently enrolled in Part D.²⁴ Some beneficiaries with limited income and resources may qualify for the low-income subsidy (LIS), which provides assistance with their Part D premiums, cost sharing, and other out-of-pocket expenses. In 2013 an estimated 11.3 million Medicare beneficiaries qualified for low-income subsidies.²⁵ Medicare beneficiaries who qualify for Medicaid based on their income and assets (dual-eligibles), who are recipients of Medicare Savings Programs, or who receive Supplemental Security Income are automatically eligible for the full LIS. Others who do not qualify for one of the above, but who have limited assets and incomes below 150% of FPL may also be eligible for the LIS and receive assistance for some portion of their premium and cost sharing charges. About 30% of Part D enrollees qualify for the LIS.

Prescription drug coverage is provided through private prescription drug plans (PDPs), which offer only prescription drug coverage, or through MA prescription drug plans which offer prescription drug coverage that is integrated with the health coverage provided under Part C. Part D plan sponsors determine payments for drugs and are expected to negotiate prices with drug manufacturers, which may involve an agreement from the manufacturer to provide a rebate. Under Medicaid, basic prescription drug rebates are determined by the larger of either a comparison of a drug's quarterly average manufacturers' price (AMP) to the best price for the same period, or a flat percentage (23.1%) of the drug's quarterly AMP. The basic rebate percentage for multi-source, non-innovator, and all other drugs is 13% of AMP.

President's Proposal

Beginning in 2016, the President's budget would require drug manufacturers to pay the difference between rebates provided to Part D plans and the corresponding Medicaid rebate levels for brand name and generic drugs provided to LIS beneficiaries. Manufacturers would be required to provide an additional rebate for brand-name and generic drugs when prices for the drugs rise faster than the rate of inflation. *This proposal is a modification of a legislative proposal from the President's FY2014 Budget.*

²⁴ *Medicare and Medicaid Statistical Supplement, 2013 Edition*, Table 14.5, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2013.html>.

²⁵ *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, May 31, 2013, Table IV.B8, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2013.pdf>.

Accelerate Manufacturer Drug Discounts to Provide Relief to Medicare Beneficiaries in the Coverage Gap

Current Law

The Medicare Part D standard drug benefit includes a coverage gap or “doughnut hole”—a period when enrollees who have reached the plan's initial coverage limit, but have not yet spent enough to qualify for more generous catastrophic coverage—face higher out-of-pocket costs. In 2014, an enrollee in a standard plan pays a \$310 deductible, and 25% coinsurance or copayments on drug spending up to the initial coverage limit of \$2,850.²⁶ Between \$2,850 and the catastrophic threshold of \$6,455—the current coverage gap—a beneficiary faces higher cost sharing.

Prior to the ACA, Part D enrollees who did not receive a low-income subsidy generally paid the full cost of drugs in the coverage gap. The ACA gradually phases out the coverage gap through a combination of manufacturer discounts on brand-name drugs, and federal subsidies for brand-name and generic drugs. By 2020, enrollees in Part D standard plans will have a 25% cost share for all prescriptions from the time they meet the deductible until they reach the catastrophic limit, after which cost sharing is negligible.

In accordance with the ACA, manufacturers in 2011 began providing a 50% discount for brand-name drugs purchased in the coverage gap. From 2011 to 2020, the federal government is providing gradually increasing subsidies for brand name and generic drugs. By 2020, the government will subsidize 25% of the cost of brand-name drugs (in addition to the manufacturer's 50% discount) and 75% of the cost of generic drugs in the coverage gap.

President's Proposal

The President's budget would increase the manufacturer discount for brand-name drugs to 75% from 50%, beginning in 2016. The change would effectively eliminate the coverage gap for brand-name drugs in 2016, though federal generic drug subsidies continue to be phased in through 2020. *This proposal was included in the President's FY2014 Budget.*

Establish Quality Bonus Payments for Part D Plans Based on Quality Star Ratings

Current Law

CMS uses a Star Ratings system to assess the quality of Part D stand-alone PDP and MA plans with a prescription drug component (MA-PD). PDP sponsors are rated on up to 15 quality and performance measures, while MA-PD plan sponsors are evaluated on up to 48 measures. A 5-star rating is excellent; a 4-star rating is above average; a 3-star rating is average; a 2-star rating is below average; and a 1-star rating is poor. The average PDP star rating (weighted by enrollment) is 3.04 for 2014.²⁷ About 37% of PDPs have a 2014 rating of four or more stars, accounting for about 9% of PDP enrolment. The average star rating for MA-PDs (weighted by enrollment) is

²⁶ CMS, “2014 Final Call Letter,” April 1, 2013, p. 58, <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Announcement2014.pdf>.

²⁷ CMS, “2014 Part C & D Medicare Star Ratings Data,” available at <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html>.

3.84 for 2014. About 38% of MA-PDs have a 2014 ranking of four stars or higher, accounting for about 52% of MA-PD enrollees.²⁸

Under Medicare Part D, private insurers provide drug coverage and bear part of the financial risk of the program. Congress designed Part D as a market-oriented program, with insurers competing for enrollees by offering lower prices or more generous benefits. Part D is not wholly market-based; the federal government provides substantial subsidies to participating plans. On average, beneficiary premiums represent roughly 25% of the cost of a standard Part D plan, as determined through annual bids submitted by insurers.

President's Proposal

The President's budget would allow CMS to revise the Part D payment system to reimburse prescription plans based on their Star Rating. Plans earning four stars or higher would have a larger portion of their costs reimbursed by CMS, while plans with ratings below four stars would receive a smaller subsidy. The proposal is based on a similar MA quality bonus payment program. *This proposal was not included in the President's FY2014 Budget.*

Suspend Coverage and Payment for Questionable Part D Prescriptions

Current Law

Recent investigations of the Part D program, including a 2011 Government Accountability Office (GAO) study, found that some beneficiaries had obtained overlapping prescriptions from multiple physicians for frequently abused prescription drugs.²⁹ CMS has taken several actions to reduce the potential for inappropriate utilization of Part D prescription drugs, with an emphasis on opioids and acetaminophen. CMS has instructed plan sponsors to institute controls at the point of sale to better control access to medications and to use quantity limits to guard against over-utilization of drugs. Plan sponsors must institute closer reviews of filled prescriptions to identify at-risk beneficiaries and enter into case management with the beneficiaries' prescribers.

President's Proposal

This President's proposal would give the Secretary authority to suspend Part D coverage and payment for drugs prescribed by providers who mis-prescribe or overprescribe drugs that have the potential to be abused by beneficiaries. The Secretary would be allowed to suspend coverage and payment for Part D prescription drugs when the prescriptions present an imminent risk to patients. In addition, the proposal would allow the Secretary authority to require that providers include additional information on certain Part D prescriptions, such as diagnosis codes, in order to obtain coverage. *This proposal was not included in the President's FY2014 Budget.*

²⁸ CMS, "2014 Part C & D Medicare Star Ratings Data," available at <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html>.

²⁹ Government Accountability Office, "Medicare Part D: Instances of Questionable Access to Prescription Drugs," September 2011, <http://www.gao.gov/assets/590/585424.pdf>.

Encourage the Use of Generic Drugs by Low Income Beneficiaries

Current Law

LIS beneficiaries enrolled in Medicare Part D may qualify for additional assistance with some, or all, of their prescription drug cost sharing. LIS beneficiary cost sharing varies by income, and is adjusted annually.

For 2014:

- Dual-eligible beneficiaries (who qualify for both Medicare and Medicaid) who are institutionalized or are receiving home and community-based services have no drug copays or coinsurance;
- Full-benefit, dual-eligible LIS beneficiaries with income less than 100% of FPL have a \$1.20 copay for generic drugs and \$3.60 for brand-name drugs, until they reach the catastrophic threshold, when their copayment is zero;
- Full-benefit, dual-eligible LIS beneficiaries with income above 100% of FPL, and other LIS beneficiaries with incomes up to 135% of FPL and limited assets, pay \$2.55 for a generic drug prescription and \$6.35 for a brand-name drug until they reach the catastrophic threshold, when their copayment is zero.
- Other beneficiaries with incomes up to 150% of FPL and limited assets pay a flat 15% coinsurance rate for all drugs up to the catastrophic threshold, cost sharing above that level of \$2.55 for a generic drug or preferred, multiple-source drug prescription, and \$6.35 for a brand-name drug.

LIS beneficiaries are more likely to have multiple, chronic ailments than other Part D beneficiaries and also are more likely to have higher drug costs. At the same time, a smaller share of LIS beneficiary prescriptions is filled with lower-cost, generic drugs, as compared to non-LIS beneficiaries. CMS data show that non-LIS enrollees had a generic dispensing rate of about 80% in 2011, compared to about 75% for LIS enrollees.³⁰ Part D plan sponsors often use incentives, such as higher copayments for expensive drugs, to persuade enrollees to switch to cheaper generics. Because LIS beneficiaries pay a set amount, regardless of the price of a drug, such incentives may be less successful with the LIS population.

President's Proposal

The President's budget proposes reducing copayments for generic drugs for LIS beneficiaries. At the same time, the proposal would double copayments for brand-name drugs to twice the level under current law. The Secretary would have authority to exclude brand-name drugs in therapeutic classes if therapeutic substitution was not clinically appropriate or a generic substitute was not available. LIS beneficiaries could submit an appeal to CMS to continue buying brand-name drugs at current rates. The proposed cost sharing change would not apply to LIS beneficiaries who are in an institution. Part D beneficiaries with incomes between 135% and 150% of FPL would face higher cost sharing only if they reached their plan's catastrophic coverage limit. *This proposal is a modification of a legislative proposal from the President's FY2014 Budget.*

³⁰ CMS, "2011 Medicare Part D Drug Utilization Trends," December 26, 2013, Slide 15. Available at <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/ProgramReports.html>.

Ensure Retroactive Part D Coverage of Newly-Eligible Low Income Beneficiaries

Current Law

Generally, there is a two-step process for low-income persons to gain a LIS for their Part D coverage. First, a determination must be made that they qualify for the assistance; second, they must enroll, or be enrolled, in a specific Part D plan. Some LIS individuals who have not elected a Part D plan are automatically enrolled into one by CMS. CMS identifies plan sponsors offering basic prescription drug coverage with a premium at or below the Part D low-income premium subsidy amount, set annually through a formula. If more than one sponsor in a region meets the criteria, CMS auto-enrolls beneficiaries on a random basis among available plans. There is also a “facilitated enrollment” process for enrollees in Medicare Savings programs, SSI enrollees, and persons who applied for and were approved for low-income subsidy assistance. The basic features applicable to auto-enrollment are the same for facilitated enrollment.

President's Proposal

The President's budget would allow CMS to contract with a single Part D plan to provide coverage for LIS beneficiaries while their eligibility is being processed, rather than assigning them to plans through the current, random process. This would mean that one plan would serve as the contact point for LIS beneficiaries, who must often seek reimbursement for retroactive drug claims. The single plan would be paid by CMS through an alternative method. *This proposal was included in the President's FY2014 Budget.* [This proposal affects both the Medicare and Medicaid budgets.]

Prohibit Brand and Generic Drug Manufacturers from Delaying the Availability of New Generic Drugs and Biologics

Current Law

The Drug Price Competition and Patent Term Restoration Act of 1984 (P.L. 98-417, commonly known as the Hatch-Waxman Act) established the abbreviated new drug application (ANDA) path to Food and Drug Administration (FDA) marketing approval of a generic version of a drug after a brand-name product's patent has expired. An ANDA allows a sponsor of a generic version of an FDA-approved drug to use, in the ANDA, safety and effectiveness data that the brand-name firm had provided to the FDA in its new drug application (NDA). Because the generic sponsor, therefore, does not have to repeat all of the expensive and time-consuming clinical testing FDA requires in an original NDA, generic prices generally are much lower than the brand-name product's price. The sponsor of a proposed generic product may challenge a brand-name manufacturer's patent by filing an ANDA with a paragraph IV certification (that the patent is invalid or not infringed). FDA provides to the first successful paragraph IV filer(s) a 180-day market exclusivity, not allowing another generic entry on the market during that period.

Brand-name and generic sponsors engaged in litigation within the Hatch-Waxman statutory framework sometimes conclude their litigation through settlement, rather than awaiting a formal decision from a court. In some settlements, the brand-name company pays the generic firm in exchange for the generic firm's agreement not to market the pharmaceutical. These arrangements have been termed “reverse” payments or “pay-for-delay” agreements.

President's Proposal

Beginning in FY2015, this legislative proposal presented in the President's budget would authorize the Federal Trade Commission to prohibit "pay-for-delay" agreements between brand and generic pharmaceutical companies that delay entry of generic drugs and biologics into the market. *This proposal was included in the President's FY2014 budgets.* [This proposal affects both the Medicare and Medicaid budgets.]

Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics

Current Law

The Biologics Price Competition and Innovation Act of 2009 (incorporated into the ACA) established a licensure pathway for competing versions of previously marketed biologics. In particular, the legislation creates a regulatory regime for two types of follow-on biologics, termed "biosimilar" and "interchangeable" biologics. The FDA is afforded a prominent role in determining the particular standards for biosimilarity and interchangeability for individual products.

In addition, the legislation created FDA-administered periods of data protection and marketing exclusivity for certain brand name drugs and follow-on products. Brand name biologic drugs receive four years of marketing exclusivity during which time other companies are prevented from filing an application for approval of a follow-on product. Brand biologics also receive 12 years of data exclusivity during which time the follow-on manufacturer cannot rely on the clinical data generated by the innovator firm in support of FDA approval of a competing version of the drug. Unlike market exclusivity, data protection does not block competitors that wish to develop their own clinical data in support of their application for marketing approval. In addition, applicants that are the first to establish their product is interchangeable with the brand name biologic are provided a term of marketing exclusivity.

President's Proposal

Effective in FY2015, the legislative proposal presented in the President's budget would award brand biologics seven years of data exclusivity rather than the current 12 years, and there would be no additional exclusivity periods for "minor" changes in product formulations. *This proposal was included in the President's FY2014 budgets.* [This proposal affects both the Medicare and Medicaid budgets.]

Premiums and Cost Sharing

Increase Income Related Premiums under Medicare Part B and Part D

Current Law

Most Medicare beneficiaries pay Part B premiums, which are set at 25% of the program's estimated (projected) costs per aged enrollee (i.e., enrollees who are age 65 or older). Since 2007, higher-income beneficiaries pay a larger share of premiums—35%, 50%, 65%, or 80%, depending on income. In 2014, the income thresholds for those premium shares are \$85,000, \$107,000, \$160,000, and \$214,000, respectively for single filers. (For married couples, the

corresponding income thresholds are twice those values.) The ACA imposed similar income-related premiums for Part D beginning in 2011. In addition, the ACA suspended inflation-indexing of income thresholds for Parts B and D through 2019 at 2010 levels. In 2012, about 4% of Part B enrollees were estimated to pay these higher income-related premiums.

President's Proposal

Beginning in 2018, the President's budget would increase the applicable percentage of the program's cost per aged enrollee for higher income beneficiaries to between 40% and 90%, replacing the current 35% to 80% range under current law. The proposal would also lower the highest income threshold, and increase the number of high-income brackets from four to five. The new income thresholds would be \$85,000, \$107,000, \$133,500, \$160,000, and \$196,000, and the respective applicable cost percentages would be 40%, 52.5%, 65%, 77.5%, and 90%. The proposal would also further suspend inflation-indexing of the income thresholds until 25% of beneficiaries under Parts B and D were subject to these premiums. *This proposal is a modification of a legislative proposal from the President's FY2014 Budget.*

Modify Part B Deductible for New Enrollees

Current Law

In addition to paying monthly premiums for Medicare Part B, Medicare beneficiaries also pay certain out-of-pocket cost-sharing amounts for their Part B services including an annual deductible. Prior to 2003, the amount of the Part B deductible was set in statute. MMA set the 2005 deductible level at \$110 and required that the deductible be increased each year by the annual percentage increase in the Part B expected per capita costs for enrollees aged 65 and over beginning with 2006 (rounded to the nearest \$1). The 2014 Part B annual deductible is \$147.

President's Proposal

The President's budget would increase the annual deductible by an additional \$25 in calendar years 2018, 2020, and 2022 for new Medicare enrollees. Specifically, under this proposal, there would be two categories of beneficiaries; and, the members of one group would pay a different annual deductible amount than the members in the second. The first group, comprised of beneficiaries who enroll in Medicare prior to January 1, 2018, would not be affected by this proposal and their annual Part B deductible would continue to be adjusted each year according to the current methodology. The deductible for Medicare beneficiaries in the second group, that is, those who enroll in Medicare beginning in January 1, 2018, and thereafter, would pay deductibles that would be subject to both the annual adjustments based on expected costs (current method) plus an additional increase of \$25 starting in 2018, another \$25 increase in 2020, and a third \$25 increase in 2022. For example, in a scenario under which the deductible amount remained the same through 2022 (unlikely), in 2022, new beneficiaries would pay a \$75 higher deductible than those who had been enrolled in Medicare prior to 2018. However, because deductibles are expected to grow each year due to expected growth in annual per capita costs, the application of the annual growth rate adjustments to the incrementally larger deductible amounts would mean that the difference in deductible amounts paid by individuals in the two groups would likely be higher than \$75. *This proposal was included in the President's FY2014 Budget.*

Introduce a Part B Premium Surcharge for New Beneficiaries Purchasing Near First-Dollar Medigap Coverage

Current Law

Medigap is private health insurance that supplements Medicare coverage. It typically covers some or all of Medicare's deductibles and coinsurance, and may also include additional items or services not covered by Medicare, such as coverage while traveling overseas. Medigap is available to Medicare beneficiaries who have fee-for-service Medicare Part A and voluntarily enroll in Medicare Part B by paying the monthly premium. Individuals who purchase Medigap must pay a monthly premium which is set by the insurance company selling the policy. There are 10 standardized Medigap plans with varying levels of coverage. Two of the 10 standardized plans cover Parts A and B deductibles and coinsurance in full (i.e., offer "first-dollar" coverage). In 2012, about 66% of all Medigap enrollees were covered by one of these two plans.

President's Proposal

Beginning in 2018, the President's budget would impose a Part B premium surcharge for new Medicare beneficiaries who select a Medigap plan with very low cost-sharing requirements. The surcharge would be equal to approximately 15% of the average Medigap premium (or about 30% of the Part B premium). *This proposal was included in the President's FY2014 Budget.*

Introduce Home Health Copayments for New Beneficiaries

Current Law

For beneficiaries who are eligible for Medicare-covered home health care, Medicare provides payment for a 60-day episode of home health care under a prospective payment system. The 60-day episode covers in-home skilled nursing, therapy, medical social services, and aide visits as well as medical supplies. Medicare, originally, required a 20% coinsurance for home health services covered under Part B in addition to having met the annual Part B deductible; however, legislative changes (P.L. 92-603 and P.L. 96-499) eliminated Medicare cost sharing for home health services. There are currently no Medicare cost-sharing requirements for home health services; however, beneficiaries may be responsible for copayments associated with Medicare-covered DME and osteoporosis drugs provided during a home health episode of care. In its March 2013 report, MedPAC recommended that Congress establish a per episode copayment for home health episodes that are not preceded by hospitalization or post-acute care use.

President's Proposal

Beginning in FY2018, the President's budget would institute a \$100 copayment for new beneficiaries for each home health 60-day episode with five or more visits that is not preceded by a hospital or inpatient post-acute stay. *This proposal was included in the President's FY2014 Budget.*

Administrative Proposals

Strengthen IPAB to Reduce Long-Term Care Drivers of Medicare Cost Growth

Current Law

The ACA established the Independent Payment Advisory Board (IPAB) to develop and submit detailed proposals to Congress and the President to reduce the growth rate of Medicare spending. Proposals will only be required in certain years when the CMS Chief Actuary determines that the projected Medicare per capita growth rate exceeds predetermined spending targets, and will have to meet specific savings targets. Recommendations made by the Board automatically go into effect unless Congress enacts specific legislation to prevent their implementation. The first year the Board's proposals can take effect is 2015 (which ties to the 2013 determination year). For the first five years of implementation, the target growth rate will depend on changes in consumer price indices. However, beginning with the sixth year of implementation, the Medicare target per capita growth rate will be the projected five-year average percentage increase in nominal Gross Domestic Product (GDP) per capita plus 1.0 percentage point. In its April 2013 determination, the CMS Actuary noted that the conditions for activating the IPAB trigger would not be met for 2015. Based on projections of the rate of growth in health care expenditures, the Congressional Budget Office has estimated that IPAB activity will not be triggered in any of the next 10 fiscal years.

President's Proposal

The President's budget would lower the target rate applicable for 2018 and after from GDP per capita growth plus 1 percentage point to GDP per capita growth plus 0.5 percentage points. *This proposal is a modification of a legislative proposal from the President's FY2014 Budget, which proposed lowering the target beginning in 2020.*

Integrate the Appeals Process for Medicare-Medicaid Enrollees

Current Law

The Medicare and Medicaid appeals processes differ significantly. Even within Medicare, although the processes are conceptually similar, the appeals process varies depending on whether it is for Medicare Parts A, B, C, or D. These appeal variations can produce confusion, inefficiency, and increased administrative cost for beneficiaries, providers, and states. The difficulty in navigating these appeals processes can be especially troublesome for dual-eligible beneficiaries (i.e., Medicare beneficiaries who also are eligible for Medicaid, because of their lower income).

For dual-eligible beneficiaries, Medicaid is the payer of last resort, meaning that if services are covered by Medicare, Medicare pays for dual-eligible beneficiaries first, then, if Medicaid covers the services, Medicaid pays the remaining costs. If services are only covered by Medicaid, then Medicaid is the only and primary payer. Dual-eligible beneficiaries sometimes are in the situation where coverage of an item or service under one program is possible only after the other program has denied coverage. The Medicare and Medicaid appeal process variances are important for dual-eligible beneficiaries because duals might face delays in receiving medical services and may experience care interruptions due to appeals process differences. In addition, these coordination issues can be expensive for both programs, potentially adding administrative costs and duplicative treatments.

President's Proposal

The President's budget proposes to introduce legislation that would create an integrated Medicare and Medicaid appeals process for dual-eligible beneficiaries. *This proposal was included in the President's FY2014 Budget.* [This proposal affects both the Medicare and Medicaid budgets.]

Other Proposals

Expand Medicare Data Sharing with Qualified Entities

Current Law

The ACA includes a provision that allows CMS to make standardized extracts of Medicare Parts A, B, or D claims data available to qualified entities for the purpose of publishing reports evaluating the performance of providers of services and suppliers. The ACA also required that qualified entities combine claims data from sources other than Medicare with the Medicare data when evaluating the performance of providers and suppliers.

President's Proposal

The President's budget would expand the scope of how qualified entities could use Medicare data beyond that of performance measurement. The proposal would allow qualified entities to use the data for fraud prevention activities and for value-added analysis for physicians. Also, qualified entities would be able to release raw claims data, instead of simply summary reports, to interested Medicare providers for care coordination and practice improvement. This proposal would make claims data available to qualified entities for a fee equal to Medicare's cost of providing the data. *This proposal was included in the President's FY2014 budget proposal.*

Pilot the Program of All-Inclusive Care for the Elderly to Individuals between Ages 21 and 55

Current Law

The Program of All-Inclusive Care for the Elderly (PACE) is a voluntary Medicaid and Medicare integration program established under Sections 1894 and 1934 of the Social Security Act for dual-eligible beneficiaries ages 55 and over. PACE providers receive capitated payments from both Medicaid and Medicare to cover a comprehensive package of benefits generally provided in adult day health center settings. The goal is to provide seamless coordinated care to certain low-income individuals who would otherwise require the level of care in an institution, such as a nursing facility.

President's Proposal

This proposal would create a new pilot demonstration in selected states to expand PACE eligibility to qualifying individuals who are ages 21 to 55 years old. *This proposal was not included in the President's FY2014 Budget.* [This proposal affects both the Medicare and Medicaid budgets.]

Extend the Qualified Individuals Program through 2015

Current Law

BBA97 required states to pay Medicare Part B premiums for a new group of low-income Medicare beneficiaries—Qualifying Individuals (QIs)—whose income was between 120% and 135% of FPL. BBA97 also amended the Social Security Act to provide for Medicaid payment for QIs through an annual transfer from the Medicare Part B Trust Fund to be allocated to states. States (and the District of Columbia) receive 100% federal funding to pay QI's Medicare premiums up to the federal allocation, but no additional matching beyond this annual allocation. In December 2012, there were approximately 480,400 low-income Medicare beneficiaries who received financial assistance from state Medicaid programs to pay their Part B premiums. The QI program was reauthorized and funded a number of times since it was established by BBA97, and most recently, Section 1201 of BBA authorized the QI program through March 31, 2014, and appropriated \$200 million in funding.

President's Proposal

The President's budget would extend authorization and funding for the QI program through December 31, 2015. *This proposal was included in the President's FY2014 Budget.* [This proposal affects both the Medicare and Medicaid budgets.]³¹

**Table 2. Estimated Cost/Savings for Medicare Legislative Proposals
Included in the President's FY2015 Budget Proposal**
(dollars in millions)

		<u>HHS Cost/Savings Estimates</u>		
	New (N), Modified (M), or Repeated (R) from the President's FY2014 Budget	FY2015	FY2015-FY2019	FY2015-FY2024
Medicare Part A				
Reduce Medicare Coverage of Bad Debts	R	-\$340	-\$10,510	-\$30,820
Better Align Graduate Medical Education Payments with Patient Care Costs	R	-960	-6,050	-14,640
Target Support for Graduate Medical Education	N	530	2,430	5,230
Reduce Critical Access Hospital Payments to 100% of Costs	R	-110	-690	-1,690

³¹ At the time the President's proposal was developed, the Qualifying Individual (QI) program was set to expire on March 31, 2014. However, since the President's FY2015 budget was released, the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93) extended the QI program through March 31, 2015. The Administration estimated the cost of this provision prior to the passage of PAMA. For this reason, the cost of extending the QI program through December 31, 2015, is expected to be lower than the cost listed in **Table 2**.

		HHS Cost/Savings Estimates		
	New (N), Modified (M), or Repeated (R) from the President's FY2014 Budget	FY2015	FY2015-FY2019	FY2015-FY2024
Prohibit Critical Access Hospital Designation for Facilities that are less than 10 Miles from the Nearest Hospital	R	-40	-300	-720
Adjust Payment Updates for Certain Post-Acute Care Providers	M	-1,450	-24,060	-97,860
Implement Bundled Payment for Post-Acute Care Providers	R	—	-430	-8,680
Encourage Appropriate Use of Inpatient Rehabilitation Facilities	R	-170	-1,070	-2,420
Adjust Skilled Nursing Facilities Payments to Reduce Hospital Readmissions ^a	R	—	-230	-1,860
Equalize Payments for Certain Conditions Treated in Inpatient Rehabilitation Facilities and Skilled Nursing Facilities	R	-110	-690	-1,620
Clarify the Medicare DSH Statute	R	—	—	—
Medicare Parts A and B				
Implement Value-Based Purchasing for Additional Providers ^a	N	—	—	—
Medicare Part B				
Modernize Payments for Clinical Laboratory Services ^a	R	—	-1,240	-7,890
Modify Reimbursement for Part B Drugs	R	-300	-2,660	-6,750
Exclude Certain Services from the In-Office Ancillary Services Exception	M		-2,120	-6,030
Modify the Documentation Requirement for Face-to-face Encounters for DME Claims	N	—	—	—
Medicare Part C				
Increase the Minimum Medicare Advantage Coding Intensity Adjustment	M	—	-5,850	-30,960
Align Employer Group Waiver Plan Payments with Average Medicare Advantage Plan Bids	R	—	-1,180	-3,740
Medicare Part D				
Align Medicare Drug Payment Policies with Medicaid Policies for Low-Income Beneficiaries	M	—	-31,050	-117,250

	New (N), Modified (M), or Repeated (R) from the President's FY2014 Budget	HHS Cost/Savings Estimates		
		FY2015	FY2015-FY2019	FY2015-FY2024
Accelerate Manufacturer Drug Discounts to Provide Relief to Medicare Beneficiaries in the Coverage Gap	R	—	-1,270	-7,850
Establish Quality Bonus Payments for Part D Plans Based on Quality Star Ratings	N	—	—	—
Suspend Coverage and Payment for Questionable Part D Prescriptions	N	—	—	—
Encourage the Use of Generic Drugs by Low Income Beneficiaries	M	—	-3,020	-8,490
Ensure Retroactive Part D Coverage of Newly-Eligible Low Income Beneficiaries	R	—	—	—
Prohibit Brand and Generic Drug Manufacturers from Delaying the Availability of New Generic Drugs and Biologics	R	-620	-3,630	-9,090
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics	R	—	-700	-4,020
Premiums and Cost Sharing				
Increase Income Related Premiums Under Part B and Part D	M	—	-4,320	-52,790
Modify Part B Deductible for New Enrollees	R	—	-110	-3,410
Introduce a Part B Premium Surcharge for New Beneficiaries Purchasing Near First-Dollar Medigap Coverage	R	—	-230	-2,740
Introduce Home Health Copayments for New Beneficiaries	R	—	-70	-820
Administrative Proposals				
Strengthen IPAB to Reduce Long-Term Care Drivers of Medicare Cost Growth	M	—	—	-12,940
Integrate the Appeals Process for Medicare-Medicaid Enrollees	R	—	—	—
Other Proposals				
Expand Medicare Data Sharing with Qualified Entities	R	—	—	—
Pilot the Program of All-Inclusive Care for the Elderly to Individuals Between Ages 21 and 55	N	—	—	—
Extend the Qualified Individuals Program through 2015 ^a	R	760	960	960

	New (N), Modified (M), or Repeated (R) from the President's FY2014 Budget	HHS Cost/Savings Estimates		
		FY2015	FY2015-FY2019	FY2015-FY2024
Savings from Program Integrity Proposals ^b			-120	-400
Interactions ^c		38	1,926	22,049
Total Proposals Impacting Medicare		-\$2,772	-\$96,284	-\$407,241

Source: Table created by CRS based on data from the Department of Health and Human Services, *Fiscal Year 2015 Budget in Brief: Strengthening Health and Opportunity for All Americans*, March 2014.

Notes: Totals may not add due to rounding.

DSH: Disproportionate share hospital

DME: Durable medical equipment

HHS: Health and Human Services

IPAB: Independent Payment Advisory Board

- The President's FY2015 budget was released prior to the enactment of the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93), and PAMA impacts this legislative proposal. The cost and savings estimates in this table were calculated by the Administration prior to the enactment of PAMA. For detail about how PAMA impacts this proposal, see the description of the proposal above.
- See "Program Integrity Legislative Proposals" for descriptions of the program integrity legislative proposals impacting Medicare.
- Adjusts for savings realized through IPAB and other Medicare interactions.

Medicaid Legislative Proposals

Medicaid Payments

Extend the Medicaid Primary Care Payment Increase Through 2015 and Include Mid-Level Providers

Current Law

For the most part, states establish their own payment rates for Medicaid providers. Federal statute requires that these rates be sufficient to enlist enough providers so that covered benefits will be available to Medicaid enrollees at least to the same extent they are available to the general population in the same geographic area. Low Medicaid physician payment rates in many states and their impact on provider participation have been perennial concerns for policy makers. The ACA requires that Medicaid payment rates for certain primary care services be raised to what Medicare pays for these services for 2013 and 2014. Physicians in subspecialties of family medicine, general internal medicine, and pediatrics are eligible to receive the increased primary care rates for certain primary care services. The federal government is picking up the entire cost of the increased primary care rates (i.e., the difference between Medicare payment rates and the Medicaid payment rates as of July 1, 2009) for those two calendar years. In 2015, the ACA requirement for enhanced primary care rates and the 100% federal financing of that increase expire.

President's Proposal

The President's budget proposes to extend the enhanced primary care rates with 100% federal financing through 2015. In addition, the budget proposal would expand the providers eligible for the enhanced primary care rates to mid-level providers, including physician assistants and nurse practitioners. *This proposal was not included in the President's FY2014 Budget.*

Rebase Future Disproportionate Share Hospital Allotments

Current Law

Under federal law, states are required to make Medicaid DSH payments to hospitals treating large numbers of low-income and Medicaid patients. States receive federal matching funds for making DSH payments up to a capped federal allotment that generally equals the previous year's allotment increased by the percentage change in CPI-U. In FY2013, federal Medicaid DSH allotments to states totaled \$11.5 billion. The ACA required the Secretary to make aggregate reductions in Medicaid DSH allotments for each year from FY2014 to FY2020. Since the ACA, three laws have amended the ACA DSH reductions. Under current law, Medicaid DSH allotment reductions will begin in FY2016 and end in FY2023. In FY2024, states' Medicaid DSH allotments will rebound to their pre-ACA reduced levels with annual inflation adjustments for FY2016 through FY2024.

President's Proposal

Instead of having the Medicaid DSH allotments rebound to their pre-ACA reduced levels, the President's budget proposes to extend the ACA-reduced Medicaid DSH allotment levels to FY2024 and subsequent years. The FY2024 Medicaid DSH allotments would be each state's FY2023 allotment increased by the percentage change in CPI-U, and the allotments for subsequent years would be the previous year's allotment increased by the percentage change in CPI-U. *This proposal was included in the President's FY2014 Budget.*³²

Limit Medicaid Reimbursement of Durable Medical Equipment Based on Medicare Rates

Current Law

States are generally free to set payment rates for items and services provided under Medicaid as they see fit, subject to certain exceptions and a general requirement that payment policies are consistent with efficiency, economy, and quality of care and are sufficient to provide access equivalent to the general population's access. Providers for which federal upper payment limits (UPLs) apply under Medicaid include hospitals and nursing facilities; federal regulations specify that states cannot pay more in the aggregate for inpatient hospital services or nursing facility services than the amount that would be paid for the services under the Medicare principles of reimbursement. No UPL currently applies to DME under Medicaid.

³² The President's FY2015 budget was released prior to the passage of the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93), which further amended the Medicaid DSH reductions by eliminating the FY2016 reductions, changing the reduction amounts, and extending the reductions to FY2024. Since PAMA extends the ACA Medicaid DSH reductions through FY2024, the estimated savings for this provision would be smaller than the savings listed in Table 3.

Historically, Medicare has paid for most DME on the basis of fee schedules. Unless otherwise specified by Congress, fee schedule amounts are updated each year by a measure of price inflation. MMA established a Medicare competitive acquisition program (i.e., competitive bidding) under which prices for selected DME sold in specified areas would be determined not by a fee schedule but by suppliers' bids. The first round of competitive bidding started in nine areas in January 2011. The second round started in 91 additional areas in July 2013. The Secretary is required to extend the competitive acquisition program, or use information from the program to adjust fee schedule rates in remaining areas by 2016.

President's Proposal

The President's budget would limit federal reimbursement for a state's Medicaid spending on certain DME to what Medicare would have paid in the same state for the services. *This proposal was included in the President's FY2014 Budget.*

Medicaid Coverage

Permanently Extend Express Lane Eligibility for Children

Current Law

CHIPRA created a state plan option for "Express Lane" eligibility, through September 30, 2013, whereby states are permitted to rely on a finding from specified "Express Lane" agencies (e.g., those that administer programs such as Temporary Assistance for Needy Families, Medicaid, CHIP, and Food Stamps) for (1) determinations of whether a child has met one or more of the eligibility requirements necessary to determine his or her initial eligibility, (2) eligibility redeterminations, or (3) renewal of eligibility for medical assistance under Medicaid or CHIP. ATRA permits states to rely on "Express Lane" for child eligibility determinations through September 30, 2014.

President's Proposal

The President's Budget would allow for a permanent extension of the state option to rely on "Express Lane" eligibility determinations for Medicaid and CHIP-eligible children. *This proposal was not included in the President's FY2014 Budget.* [This proposal affects both the Medicaid and CHIP budgets.]³³

Extend the Transitional Medical Assistance Program through 2015

Current Law

States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation of benefits is

³³ The President's FY2015 budget was released prior to the passage of the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93). At the time the President's proposal was developed, the state plan option for Express Lane Eligibility for Children was set to expire on September 30, 2014. However, PAMA extended the Express Lane Eligibility for children state plan option through September 30, 2015. The Administration estimated the cost of this provision prior to the passage of PAMA. For this reason, the cost of permanently extending the Express Lane Eligibility for children state plan option is expected to be lower than the cost listed in **Table 3** and **Table 5**.

known as transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families who lose Medicaid eligibility due to (1) increased spousal support collections,³⁴ or (2) an increase in earned income or hours of employment. Congress expanded work-related TMA benefits in 1988, requiring states to provide at least 6, and up to 12, months of TMA coverage to families losing Medicaid eligibility due to increased hours of work or income from employment, as well as to families who lose eligibility due to the loss of a time limited earned income disregard (such disregards allow families to qualify for Medicaid at higher income levels for a set period of time). Congress created an additional work-related TMA option in ARRA. Under the ARRA option, states may choose to provide work-related TMA for a full 12-month period rather than two 6-month periods and may waive the requirement that the family must have received Medicaid in at least 3 of 6 months preceding the month in which eligibility is lost. Congress has acted on numerous occasions to extend these expanded TMA requirements (which are outlined in Sections 1902(e)(1) and 1925 of the Social Security Act) beyond their original sunset date of September 30, 1998. Most recently, BBA extended the authorization and funding of expanded TMA requirements through March 31, 2014.

President's Proposal

The President's budget would extend authorization and funding of expanded TMA requirements through December 31, 2015, and would permit states that adopt the ACA Medicaid expansion to opt out of TMA. *This proposal was included in the President's FY2014 Budget.*³⁵

Medicaid Benefits

Provide Home and Community-Based Waiver Services to Children and Youth Eligible for Psychiatric Residential Treatment Facilities

Current Law

Section 1915(c) of the Social Security Act authorizes 1915(c) waivers, which provides the Secretary authority to waive certain Medicaid state plan requirements effectively allowing states to offer home and community-based services to additional groups of persons with long-term care needs while containing costs. Among other requirements, states must target 1915(c) waivers to specific populations, which can include individuals with mental illness. Eligible individuals must have a level of care need that would otherwise be covered under a Medicaid institutional benefit defined as either nursing facility services, services in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or inpatient hospital services.

³⁴ As of January 1, 2014, Modified Adjusted Gross Income (MAGI) rules are used in determining eligibility for most of Medicaid's non-elderly populations. The extension of eligibility for individuals losing coverage under Section 1931 due to increased child support will no longer be relevant in 2014, as child support is no longer counted as income under MAGI-based income counting methodologies.

³⁵ At the time the President's proposal was developed, the expanded TMA requirements were set to expire on March 31, 2014. However, since the President's FY2015 budget was released, the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93) extended the expanded TMA requirements through March 31, 2015. The Administration estimated the cost of this provision prior to the passage of PAMA. For this reason, the cost of extending the expanded TMA requirements through December 31, 2015, is expected to be lower than the cost listed in **Table 3**.

President's Proposal

This proposal would add services in psychiatric residential treatment facilities to the list of qualified institutional benefits for 1915(c) waivers. Thus, it would extend coverage of home and community-based services under 1915(c) waivers to eligible individuals who meet the level of care need for services in psychiatric residential treatment facilities. *This proposal was not included in the President's FY2014 Budget.*

Expand State Flexibility to Provide Benchmark Benefit Packages

Current Law

As an alternative to traditional Medicaid benefits, states may enroll certain Medicaid beneficiaries into what were once referred to as Benchmark and Benchmark-equivalent plans, but are now being called Alternative Benefit Plans (ABPs). ABPs are a Medicaid benefit structure that has different requirements than the traditional Medicaid benefits. This flexibility permits the state to define populations that will be served and the specific benefit packages that will apply. ABPs must cover at least the 10 essential health benefits that also apply to the qualified health plans offered in the private health insurance exchanges. In addition, ABP coverage must comply with the federal requirements for mental health parity, and special rules also apply with regard to prescription drugs, rehabilitative and habilitative services and devices, and preventive care. As a part of the benefit design process, CMS established a policy whereby states can use benefit substitution as a tool to fill in coverage gaps to ensure that all essential health benefits are represented and/or to align their benefit plans with traditional Medicaid state plan coverage and/or with exchange coverage. States that choose to implement the ACA Medicaid expansion are *required* to provide the individuals eligible for Medicaid through the expansion Medicaid services through ABPs (with exceptions for selected special-needs subgroups). However, states have the option to provide ABP coverage to other subgroups.

President's Proposal

The President's budget would allow benchmark-equivalent coverage for non-elderly, nondisabled adults with income that exceeds 133% of FPL. *This proposal was included in the President's FY2014 Budget.*

Medicaid Prescription Drugs

Clarify the Medicaid Definition of Brand Drugs

Current Law

For the purpose of determining prescription drug rebates, Medicaid distinguishes between two types of drugs: (1) single source drugs (generally, those still under patent) and innovator multiple source drugs (drugs originally marketed under a patent or original NDA but for which generic equivalents now are available); and (2) all other, non-innovator, multiple source drugs. Rebates for the first drug category (i.e., drugs still under patent or those once covered by patents) have two components: a basic rebate and an additional rebate. For brand name drugs, Medicaid's basic rebate is determined by the larger of either a comparison of a drug's quarterly average manufacturer price (AMP) to the best price for the same period, or a flat percentage (23.1%) of the drug's quarterly AMP. Drug manufacturers owe an additional rebate when their unit prices for

individual products increase faster than inflation. For generic drugs, manufacturers' Medicaid rebates are 13% of the drug's AMP.

Manufacturers sometimes market their patented products, or versions of their patented products, as over-the-counter (OTC) products, before their patents expire. When AMPs for OTC sales are combined with AMPs for patented product sales, drug manufacturers' Medicaid rebate obligations can be reduced because OTC prices generally are lower than AMPs.

President's Proposal

The President's budget proposes to introduce legislation clarifying that even though manufacturers had converted innovator multiple source products to OTC products, those drugs would still be considered brand name drugs for calculating Medicaid rebates. *This proposal was included in the President's FY2014 Budget.*

Apply Inflation-Associated Penalty to Medicaid Rebates for Generic Drugs

Under the federal Medicaid law, Medicaid rebate calculations for brand name drugs have two components, a basic rebate and an additional rebate. The basic rebate is the higher of a drug's best price compared to its quarterly AMP or 23.1% of AMP. An additional rebate is applied when a drug's price increased faster than the rate of inflation since the drug was first introduced to the market. The additional rebate is added to the basic rebate to get a brand drug's total rebate. Medicaid rebates for generic drugs have only a basic rebate component without an adjustment when prices rise faster than inflation.

President's Proposal

The President's FY2015 Budget proposes to require that the additional inflation adjustment brand name drug rebate also be applied to generic drugs. *This proposal was not included in the President's FY2014 Budget.*

Require the Coverage of Prescribed Prenatal Vitamins and Fluorides under the Medicaid Drug Rebate Program

Current Law

With certain exceptions, federal Medicaid law requires states participating in the Medicaid rebate program to cover all outpatient drugs offered by drug manufacturers that have signed drug pricing agreements with the Secretary. Medicaid law excludes certain drugs from the coverage requirement.³⁶ The excluded drug list identifies prescription vitamins and minerals as drugs that states have the option of not covering, even when considered medically necessary. However, federal Medicaid law exempts prenatal vitamins and fluoride preparations. Even though prenatal vitamins and fluoride preparations are identified as exceptions to the prescription vitamin and

³⁶ See Social Security Act §1927(d)(2), List of Drugs Subject to Restriction. The Medicaid excluded drug list includes eight drugs, classes of drugs or their medical uses. Unlike other outpatient drugs, under Medicaid states can choose to restrict coverage of the excluded drugs. With some exceptions, if states choose to cover excluded drugs, they will receive federal financial participation (FFP). Examples of Medicaid excluded drugs include the following: drugs for treatment of anorexia, weight loss or gain; fertility drugs; cough or common cold drugs; drugs for hair growth or cosmetic purposes; and prescription vitamins and minerals, except prenatal vitamins and fluoride preparations.

mineral exclusion, there may have been confusion that states were required to cover these drugs when they were determined to be medically necessary.

President's Proposal

This proposal would clarify that prenatal vitamins and fluoride preparations are covered outpatient drugs, meaning states must cover these products under the Medicaid drug rebate program if they are considered medically necessary. *This proposal was not included in the President's FY2014 Budget.*

Correct the ACA Medicaid Rebate Formula for New Drug Formulations

Current Law

Under previous law, modifications to existing drugs—new dosages or formulations—generally were considered new products for purposes of reporting AMPs to CMS. As a result, when drug makers introduced new formulations of existing products they sometimes would have lower additional rebate obligations for these line-extension products. For example, manufacturers have developed extended-release formulations of existing products which, because they were considered new products under previous Medicaid drug rebate rules, were given new base period AMPs. The new base period AMPs for line-extension products would be higher than the original product's AMP. For line-extension products, manufacturers are less likely to owe additional rebates since the product's AMP would not have had time to have risen faster than the rate of inflation. ACA included a provision that required manufacturers to pay Medicaid rebates (both basic and additional rebates) on line-extension products as if they were the original product on which the line extension was based.³⁷

President's Proposal

The President's budget would make a technical correction to an ACA provision that amended federal Medicaid law to ensure that Medicaid rebates were applicable to line-extension drugs by removing the word "original" from the definition of single source and innovator multiple source drugs. *This proposal was included in the President's FY2014 Budget.*

Limit Dispute Resolution Timeframe in the Medicaid Drug Rebate Program to Twelve Quarters

Current Law

Under Medicaid law, in order for drug manufacturers to sell their products to state Medicaid programs they must agree to the conditions of the Medicaid Drug Rebate (MDR) program. Among other MDR requirements, drug manufacturers must pay state Medicaid programs rebates on covered outpatient drugs and report certain drug pricing information. States report the amount of drugs used, then drug manufacturers compute Medicaid drug rebates for each drug, then send states rebates for all drugs used during the reporting period. Manufacturers have the right to audit the drug utilization information reported by states. Drug manufacturers may dispute MDRs and

³⁷ ACA §2501(d), Additional Rebate For New Formulations of Existing Drugs. For more information, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, page 37.

are not restricted by federal Medicaid law to a time limit in which to dispute states' drug rebate claims, so manufacturers can dispute rebates as far back as 1991 when the rebate program started.

President's Proposal

The President's budget would establish a 12-quarter time limit for manufacturers to dispute state utilization data. The time limit would provide an incentive to manufacturers and states to resolve outstanding disputes. *This proposal was not included in the President's FY2014 Budget.*

Exclude Authorized Generics from Medicaid Brand-Name Rebate Calculations

Current Law

Authorized generics are drugs that the original patent holder has licensed to a generic drug manufacturer to sell at a negotiated, reduced price. It is argued that authorized generics raise prices for consumers and reduce incentives for generic manufacturers to challenge single source drug patents. Including authorized generic sales with brand product sales has the effect of lowering a product's AMP, thereby decreasing manufacturers' Medicaid rebate obligations for those products (both the basic and the additional rebate might be decreased).³⁸

President's Proposal

The President's budget would change the calculation of Medicaid rebates for single source (i.e., brand name) products to exclude sales of authorized generic drugs. By removing authorized generic sales from the single source product's AMP calculation, the AMP would be higher thus increasing the rebate owed by manufacturers on brand name drugs. *This proposal was included in the President's FY2014 Budget.*

Exclude Brand and Authorized Generic Drug Prices from the Medicaid Federal Upper Limits

Current Law

The ACA refined the definition of Medicaid multiple-source, generic, drugs. The ACA increased the number of drugs considered by the FDA as therapeutically and pharmacologically equivalent products from two to three, which requires the Secretary to establish federal upper limits (FULs) for those products. Medicaid prescription drug FULs are used to limit reimbursement for certain multiple source drugs. Medicaid drug FULs are calculated based on the weighted average price of all drugs, brand, authorized generic, and generic drugs, under each product code.

President's Proposal

The President's budget would specify that the amounts paid for brand and authorized generics would be excluded from the Medicaid prescription drug FUL calculations. *This proposal was included in the President's FY2014 Budget.*

³⁸ Medicaid collects an additional rebate from drug manufacturers when their products prices rise faster than the rate of inflation. The additional rebates also would increase if sales of authorized generics are excluded from the calculation of brand-name drug AMPs.

Require Manufacturers that Improperly Report Items for Medicaid Drug Coverage to Fully Repay States

Current Law

Drug manufacturers that want to sell their products to Medicaid programs must agree to pay rebates for drugs provided to Medicaid beneficiaries. Under the terms of the Medicaid drug rebate program, manufacturers must make their entire product line available, and Medicaid must cover all of a manufacturer's products, except certain drugs drug classes, or uses identified in law on an "excluded drug list."³⁹ Rebates paid by manufacturers to Medicaid are calculated based on each manufacturer's AMP for a drug. AMP is defined in law.⁴⁰ Studies and legal settlements between drug manufacturers and state Medicaid programs have shown some irregularities in how manufacturers interpreted CMS guidance on what sales transactions should be included in AMP. States are permitted to exclude coverage of drugs on the excluded drug list, but they also may cover these drugs. Manufacturers sometimes include excluded drug sales transactions and other non-FDA approved products in their AMP calculations. By including these excluded and non-approved drug sales in the calculation of AMP, rebates owed to states can be reduced.

President's Proposal

The President's budget proposal would require manufacturers that improperly reported drugs not covered by Medicaid in their AMP calculations to fully compensate states for the drug rebates the manufacturers would have owed to states if non-covered drugs were not included in AMP. *This proposal was included in the President's FY2014 budget proposal.*

Enforce Manufacturer Compliance with Drug Rebate Requirements

Current Law

CMS has authority to survey drug manufacturers, and HHS OIG has authority to audit drug manufacturers. CMS and OIG monitor Medicaid prescription drug prices submitted by manufacturers and the rebates these companies pay to the Medicaid program, which are shared between states and the federal government. CMS conducts automated data checks on the drug prices reported by manufacturers and notifies manufacturers when it identifies discrepancies or errors. There is substantial variation in the methodologies and assumptions drug manufacturers follow in reporting drug price data to CMS. Even though drug manufacturers' methodologies and assumptions for reporting drug prices can have a great impact on rebates, CMS does not generally verify that manufacturers' documentation supports their prices and does not routinely check that their price determinations are consistent with the Medicaid statute, regulations, or the rebate agreement. Studies have found and False Claims Act settlements have shown irregularities in manufacturers' drug price reporting. The ACA made a number of changes to Medicaid prescription drug pricing policies, including provisions to create more uniform manufacturer drug reporting standards.

³⁹ See Social Security Act §1927(d)(2).

⁴⁰ CMS published a Notice of Proposed Rule Making with guidance for manufacturers and other stakeholders on calculation of average manufacturer price and other Medicaid drug rebate issues. For more information, see Centers for Medicare & Medicaid, "Medicaid Program; Covered Outpatient Drugs," 77 *Federal Register* 5318, February 2, 2012.

President's Proposal

The President's budget would require to the extent they are cost effective, that regular audits and surveys of drug manufacturers be conducted to evaluate manufacturers' compliance with drug rebate agreements, the Medicaid statute, and regulations. *This proposal was included in the President's FY2014 budget proposal.*

Require Drugs be Electronically Listed with FDA to Receive Medicaid Coverage

Current Law

Under federal law and regulation, outpatient prescription drugs may be covered by Medicaid if the drugs were approved for safety and effectiveness by the FDA under the Federal Food Drug and Cosmetics Act (P.L. 75-717). The FDA approves drugs when a manufacturer obtains a New Drug Approval, generally for sole source brand name drugs, or where a manufacturer obtains an ANDA, generally for multiple source, generic drugs. Federal regulations limit Medicaid reimbursement for outpatient drugs prescribed off label to those indications where a drug is listed in one or more of several named compendia, which are reference documents that list how most drugs could be used both on-label and off-label. Even though current law requires drug manufacturers to list their products with the FDA, not all drugs on the market are properly listed. CMS published a proposed guidance on changes authorized by the ACA.⁴¹

President's Proposal

The President's budget would require that drug manufacturers list their products electronically with the FDA in order to be covered and reimbursed by Medicaid. This proposal also would align Medicaid drug coverage requirements with Medicare's requirements. *This proposal was included in the President's FY2014 budget proposal.*

Increase Penalties for Fraudulent Noncompliance on Rebate Agreements

Current Law

Drug manufacturers that want to sell products to state Medicaid programs must agree to offer rebates to states, which are shared with the federal government. As part of the Medicaid rebate agreement, drug manufacturers are required to report accurate drug price information to CMS so it can compute or verify drug rebates. CMS guidance permits manufacturers to make "reasonable assumptions" consistent with the "intent" of the law, regulations, and rebate agreement. Thus, manufacturers determine which sales transactions to include when reporting prices to CMS. Provisions in the ACA amended the Medicaid drug rebate statute, and CMS published a proposal that would implement ACA's Medicaid drug rebate changes. Individuals, including an organization, agency, or other entity, who knowingly make or cause to be made false statements, omissions, or misrepresentations of material fact in applications, bids, or contracts could be subject to fines, program exclusions, and/or criminal penalties. However, the civil monetary and

⁴¹ CMS published a Notice of Proposed Rule Making that proposed changes and clarified Medicaid drug program definitions, including the requirements that covered drugs be electronically listed with the FDA. See Centers for Medicare & Medicaid, "Medicaid Program; Covered Outpatient Drugs," 77 *Federal Register* 5318, February 2, 2012. A final rule has not been published.

criminal provisions applicable to all federal health care programs are not specifically designed to address Medicaid drug rebate reporting violations.

President's Proposal

The President's budget proposed to increase penalties on drug manufacturers that knowingly report false information under Medicaid drug rebate pricing agreements that are used to calculate Medicaid rebates. *This proposal was included in the President's FY2014 budget proposal.*

Provide Continued Funding for Survey of Retail Pharmacy Prices

Current Law

Section 6001 of DRA amended the Social Security Act to require the Secretary to survey retail pharmacy prices and appropriated \$5 million annually for five years to fund the survey and other reporting requirements. The retail price survey was to be a nationwide survey of average consumer prices of outpatient drugs, net of all discounts and rebates (price concessions). In order to obtain information on retail consumer prices and price concessions, CMS implemented a two part survey where Part I collected consumer price information and Part II collected information on pharmacies' acquisition costs. Acquisition cost is used to help states set reasonable prescription drug payment rates. CMS retained a vendor to assist in the survey, but suspended the consumer price survey in July 2013 due to budget limitations.

President's Proposal

The President's budget proposes to provide a mandatory annual \$6 million appropriation for five years to sustain the nationwide retail pharmacy survey and incorporate cash, third-party insured, and Medicaid purchase price information. The proposal also would fund the collection of acquisition cost data from retail community pharmacies. *This proposal was not included in the President's FY2014 Budget.*

Require Drug Wholesalers to Report Wholesale Acquisition Costs to CMS

Current Law

Even though the Social Security Act gives the Secretary authority to survey wholesalers to verify manufacturer prices when necessary, the statute does not provide the authority to collect wholesale prices on a regular basis nor does the authority apply the data collection to all Medicaid-covered drugs. To determine if drug manufacturers are accurately reporting required pricing information on AMP, ASP, and where appropriate, best price, it would be necessary for CMS to collect wholesale acquisition cost data from drug wholesalers.

President's Proposal

This proposal would give the Secretary authority to survey wholesale acquisition costs for all Medicaid-covered drugs on a regular basis. The proposal also would enable CMS to verify AMPs that currently are being reported by drug manufacturers and to better set Medicaid drug FULs. *This proposal was not included in the President's FY2014 Budget.*

Other

Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care

Current Law

Nearly all children in foster care are eligible for Medicaid and are generally entitled to the same set of Medicaid benefits as other children enrolled in Medicaid, including coverage for psychotropic medications (i.e., prescribed drugs that affect the brain chemicals related to mood and behavior to treat a variety of mental health conditions). Certain factors, such as longer involvement with the child welfare agency, being of school age, and living in a group setting, forecast a greater chance that a child in foster care takes psychotropic medications. Little research has been conducted to show that psychotropics are effective and safe for children with mental health disorders. Federal child welfare law (Title IV-B, Subpart 1 of the Social Security Act) requires states to provide HHS with information about protocols they have in place for the appropriate use and monitoring of psychotropic medication.

President's Proposal

The President's budget proposes a five-year joint initiative between CMS and the Administration for Children and Families (ACF), which administers child welfare programs and activities, to provide performance-based incentive payments to states through Medicaid in order to reduce reliance on psychotropic medications for children in foster care by encouraging the use of evidence-based screening, assessment, and treatment of trauma and mental health disorders. ACF would receive separate funding to provide competitive grants for related purposes. *This proposal was not included in the President's FY2014 Budget.*

Establish Hold-Harmless for Federal Poverty Guidelines

Current Law

The HHS poverty guidelines (also referred to as the FPL) are a simplified version of the poverty thresholds that the Census Bureau uses to prepare its estimates of the number of individuals and families in poverty. The HHS poverty guidelines are published annually in the Federal Register (usually in January) and are used for administrative purposes such as determining financial eligibility for certain federal programs, including Medicaid. Federal law requires the Secretary to update the poverty guidelines at least annually by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the CPI-U as calculated by the Bureau of Labor Statistics. After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes. The 2014 poverty guidelines reflect actual price changes between calendar years 2012 and 2013.

President's Proposal

The President's budget would establish a permanent hold harmless provision to ensure that the HHS poverty guidelines are only adjusted when there is an increase in the CPI-U, which would prevent individuals from losing Medicaid coverage if CPI-U is negative. The provision would impact social programs that rely on the poverty guidelines for administrative purposes (such as

Medicaid, Supplemental Nutrition Assistance Program, Women, Infants and Children, etc.). *This proposal was included in the President's FY2014 Budget.*

Extend Special Immigrant Visa Program

Current Law

A special immigrant visa program for Afghans originally established under the Omnibus Appropriations Act, 2009 (P.L. 111-8) makes Afghan nationals eligible for special immigrant visas if they were employed by or on behalf of the U.S. government in Afghanistan for not less than one year during a specified period and meet other requirements. This special immigrant visa program was capped at 1,500 principal aliens (excluding spouses and children) annually for FY2009-FY2013 and is capped at 3,000 principal aliens for FY2014. The statute allows for unused visa numbers to be carried forward from one year to the next through FY2015. Foreign nationals with special immigrant visas are granted legal permanent resident (LPR) status upon admission to the United States. As a result, Afghans granted special immigrant visas under this program are eligible for the same resettlement assistance, entitlement programs, and other federal benefits as refugees.

President's Proposal

The President's budget would provide for up to 3,000 special immigrant visas to be issued to principal aliens under this program in FY2015 and would allow for unused visa numbers to be carried forward through FY2016. *This proposal is a modification of a legislative proposal from the President's FY2014 Budget.*

Extend Supplemental Security Income Time Limits for Qualified Refugees

Current Law

SSI, which provides means-tested cash benefits to aged, blind, and disabled persons, is generally only available to U.S. citizens and in some limited cases, certain legal permanent residents of the United States. However, certain classes of refugees; asylees; and other humanitarian immigrants, such as Cuban and Haitian entrants or Iraqi and Afghan special immigrants may receive SSI benefits for up to seven years after entering the United States or attaining refugee status. If, after the conclusion of this seven-year period, a refugee, asylee, or humanitarian immigrant has not attained citizenship or permanent resident status, then he or she is ineligible for any future SSI benefit payments.

President's Proposal

The President's budget proposes to extend the current seven-year period of SSI eligibility for refugees, asylees, and humanitarian immigrants to nine years through the end of FY2016. At the end of FY2016, the eligibility period for refugees, asylees, and humanitarian immigrants would return to seven years. *This proposal was included in the President's FY2014 Budget.*

Eliminate Medicaid Recoupment of Birthing Costs from Child Support

Current Law

Currently, if a custodial parent has no private medical coverage at the time of her child's birth, the father can be held financially responsible for payment of the birth costs. Federal law (Section 1902(a)(25)(F) of the Social Security Act) permits states to use the Child Support Enforcement program to collect money from noncustodial fathers to reimburse Medicaid for birth costs of children receiving Medicaid benefits.

President's Proposal

The President's budget proposes to prohibit the use of child support to repay Medicaid costs associated with giving birth—a practice retained by 10 states. *This proposal was included in the President's FY2014 Budget.*

**Table 3. Estimated Cost/Savings for Medicaid Legislative Proposals
Included in the President's FY2015 Budget Proposal**

(dollars in millions)

		HHS Cost/Savings Estimates		
	New (N), Modified (M), or Repeated (R) from the President's FY2014 Budget	FY2015	FY2015-FY2019	FY2015-FY2024
Medicaid Payments				
Extend the Medicaid Primary Care Payment Increase through 2015 and Include Mid-Level Providers (Workforce Initiative)	N	\$4,060	\$5,440	\$5,440
Rebase Future Disproportionate Share Hospital Allotments ^a	R	—	—	-3,260
Limit Medicaid Reimbursement of Durable Medical Equipment Based on Medicare Rates	R	-195	-1,300	-3,135
Medicaid Coverage				
Permanently Extend Express Lane Eligibility for Children ^{a, b}	N	20	245	770
Extend the Transitional Medical Assistance Program through 2015 ^a	R	920	1,550	1,550
Extend the Qualified Individual Program through 2015 ^{a, c}	R	—	—	—
Medicaid Benefits				
Provide Home and Community-Based Waiver Services to Children and Youth Eligible for Psychiatric Residential Treatment Facilities	N	75	770	1,908
Expand State Flexibility to Provide Benchmark Benefit Packages	R	—	—	—

		HHS Cost/Savings Estimates		
	New (N), Modified (M), or Repeated (R) from the President's FY2014 Budget	FY2015	FY2015-FY2019	FY2015-FY2024
Medicaid Prescription Drugs				
Clarify the Medicaid Definition of Brand Drugs	R	-16	-100	-205
Apply Inflation-Associated Penalty to Medicaid Rebates for Generic Drugs	N		-150	-1,225
Require the Coverage of Prescribed Prenatal Vitamins and Fluorides under the Medicaid Drug Rebate Program	N	—	—	—
Correct the ACA Medicaid Rebate Formula for New Drug Formulations	R	-270	-2,610	-5,880
Limit Dispute Resolution Timeframe in the Medicaid Drug Rebate Program to Twelve Quarters	N	—	—	—
Exclude Authorized Generics from Medicaid Brand-Name Rebate Calculations	R	-20	-100	-200
Exclude Brand and Authorized Generic Drug Prices from the Medicaid Federal Upper Limits	R	-30	-430	-1,040
Require Manufacturers that Improperly Report Items for Medicaid Drug Coverage to Fully Repay States	R	-1	-5	-10
Enforce Manufacturer Compliance with Drug Rebate Requirements	R	—	—	—
Require Drugs be Electronically Listed with FDA to Receive Medicaid Coverage	R	—	—	—
Increase Penalties for Fraudulent Noncompliance on Rebate Agreements	R	—	—	—
Provide Continued Funding for Survey of Retail Pharmacy Prices	N	6	30	30
Require Drug Wholesalers to Report Wholesale Acquisition Costs to CMS	N	—	—	—
Prohibit Brand and Generic Drug Manufacturers from Delaying the Availability of New Generic Drugs and Biologics ^d	R	—	-50	-190
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics ^d	R	-150	-860	-1,960
Ensure Retroactive Part D Coverage of Newly Eligible Low-Income Beneficiaries ^d	R	—	—	—

Other

	New (N), Modified (M), or Repeated (R) from the President's FY2014 Budget	HHS Cost/Savings Estimates		
		FY2015	FY2015-FY2019	FY2015-FY2024
Integrate the Appeals Process for Medicare-Medicaid Enrollees ^d	R	—	—	—
Pilot the Program of All-Inclusive Care for the Elderly to Individuals Between the Ages of 21 and 55 ^d	N	—	—	—
Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care	N	130	675	665
Establish Hold-Harmless for Federal Poverty Guidelines	R	—	—	—
Extend Special Immigrant Visa Program	M		17	36
Extend Supplemental Security Income Time Limits for Qualified Refugees	R	11	23	23
Eliminate Medicaid Recoupment of Birthing Costs from Child Support	R	—	—	—
Savings from Program Integrity Proposals ^e		-19	-275	-620
Total Proposals Impacting Medicaid		\$4,521	\$2,870	-\$7,303

Source: Table created by CRS based on data from the Department of Health and Human Services, *Fiscal Year 2015 Budget in Brief: Strengthening Health and Opportunity for All Americans*, March 2014.

Notes: Totals may not add due to rounding.

ACA: Patient Protection and Affordable Care Act (P.L. 111-148)

FDA: Food and Drug Administration

HHS: Health and Human Services

- The President's FY2015 budget was released prior to the enactment of the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93), and PAMA impacts this legislative proposal. The cost and savings estimates in this table were calculated by the Administration prior to the enactment of PAMA. For detail about how PAMA impacts this proposal, see the description of the proposal above.
- Medicaid impact of the legislative proposal. See the CHIP table for the CHIP impact of this legislative proposal.
- States pay Medicare Part B premium costs for Qualified Individuals that are in turn offset by a reimbursement from Medicare Part B. Costs of the proposal to extend the Qualified Individuals program are reflected in the table with the cost and savings for Medicare legislative proposals.
- These proposals impact both the Medicare and Medicaid programs. See the "Medicare Legislative Proposals" section for descriptions of these legislative proposals.
- See "Program Integrity Legislative Proposals" for descriptions of the program integrity legislative proposals impacting Medicaid.

Program Integrity Legislative Proposals

Medicare

Allow Prior Authorization for Medicare Fee-for-service Items

Current Law

Under current law, Medicare covers DME, including power wheelchairs and other power mobility devices (PMDs), when it is determined to be medically necessary. There is a history of fraud and abuse associated with DME and PMDs, wherein beneficiaries receive PMDs that are not medically necessary, or Medicare is charged for equipment that is never delivered. CMS began a demonstration in 2012 that requires PMDs in seven states (California, Illinois, Michigan, New York, North Carolina, Florida, and Texas) receive Medicare prior authorization, before beneficiaries receive equipment.

Medicare also covers certain imaging services. Over the last decade, the growth of imaging services provided under the Medicare program has exceeded those of most other Part B services. From 2000 through 2006, the Government Accountability Office (GAO) has found that “spending on advanced imaging, such as CT scans, MRIs, and nuclear medicine, rose substantially faster than other imaging services such as ultrasound, X-ray, and other standard imaging.” More recently, another GAO study found that “[f]rom 2004 through 2010, the number of self-referred and non-self-referred advanced imaging services—magnetic resonance imaging (MRI) and computed tomography (CT) services—both increased, with the larger increase among self-referred services.” These and other findings raise concerns about whether advanced imaging services are being used appropriately in the Medicare program.

President's Proposal

The President's budget proposal would continue extend the Secretary's authority to require prior authorization for all Medicare fee-for-service items. In addition, the proposal would require the Secretary to continue the Medicare PMD prior-authorization demonstration and adopt prior authorization for advanced imaging services. *This proposal is a modification of a legislative proposal from the President's FY2014 Budget.*

Allow Civil Monetary Penalties for Providers and Suppliers who Fail to Update Enrollment Records

Current Law

Participating Medicare providers and suppliers are required to submit updated enrollment information within specified time frames. CMS uses provider/supplier enrollment records to monitor provider status. Current provider records help to ensure that providers who could pose a higher risk of fraudulent activity receive greater scrutiny when applying and afterwards in submitting reimbursement claims.

President's Proposal

The President's budget would authorize the Secretary to impose civil penalties when providers and suppliers fail to update enrollment records on a timely basis. *This proposal was included in the President's FY2014 budget proposal.*

Allow the Secretary to Create a System to Validate Practitioners' Orders for Certain High Risk Items and Services

Current Law

Claims processing systems currently do not contain data that could be used to determine if a patient actually saw a practitioner or whether services billed on a claim were determined to be medically necessary. Many providers and health systems are implementing electronic health records (EHR) systems. Provisions in ARRA and the ACA provided financial incentives to providers to invest in EHR. Many EHR systems either are linked or have the capability to interact with clinical decision support systems and electronic claims processing. Electronic patient records may contain information on what services practitioners ordered, whereas claims processing systems only have information necessary to request reimbursement from payers, such as Medicare, Medicaid, or CHIP. As these EHR and claims processing systems become the standard of practice, it may be possible for program integrity systems to routinely validate that practitioners ordered specific treatments, tests, or other procedures at high risk for fraud. Current law does not specifically require the Secretary to develop or implement a system for validating practitioner orders for high-risk services.

President's Proposal

The President's budget would implement an electronic Medicare claims ordering system that could validate whether practitioners determined high-risk services were medically necessary and whether patients received those services. *This proposal was included in the President's FY2014 budget proposal.*

Increase Scrutiny of Providers Using Higher-Risk Banking Arrangements to Receive Medicare Payments

Current Law

There is no restriction or increased oversight when providers employ banking arrangements, such as sweep accounts and wire-transfers to off-shore accounts that might be at higher risk of fraudulent activities. In some cases, Medicare has been unable to recover improper payments because providers quickly transferred Medicare's payments to other jurisdictions. These providers were able to shield large Medicare payments from recovery actions because the improper payments were deposited into accounts where federal prosecutors had limited authority.

President's Proposal

The President's budget proposes to authorize the Secretary to require Medicare providers and suppliers to report the use of accounts that immediately transfer funds to sweep accounts in other jurisdictions where it might be difficult for Medicare to recover improper payments from these providers. *This proposal was included in the President's FY2014 budget proposal.*

Retain a Percentage of Incentive Reward Program Recoveries

Current Law

The Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191) required the Secretary to establish a Medicare incentive reward program to encourage individuals to report cases of suspected fraud or abuse. The HIPAA incentive reward program authorized the Secretary to pay a portion of amounts collected to individuals who identified cases of suspected misconduct. Individuals are eligible to collect a maximum of 10% of the recovered overpayments or \$1,000, whichever is less. CMS proposed to expand the incentive reward program by, among other things, increasing the amount an individual could collect to 15% of the final amount collected applied to the first \$66 million.

President's Proposal

The President's budget would authorize the Secretary to retain a portion of the overpayment recoveries identified by individuals to administer the incentive reward program. *This proposal was not included in the President's FY2014 Budget.*

Medicaid

Support Medicaid Fraud Control Units for the Territories

Current Law

The territories⁴² operate Medicaid programs under rules that differ from those applicable to the states and the District of Columbia. For example, the federal Medicaid funding to the states and the District of Columbia is open-ended, but the Medicaid programs in the territories are subject to annual federal spending caps. The territories are supposed to abide by many of the same Medicaid requirements as the 50 states and the District of Columbia, but it has been documented that the Medicaid programs in the territories do not include all of the federal mandates. For instance, federal law requires each state to have a Medicaid Fraud Control Unit (MFCU), but territories do not have MFCUs.⁴³

MFCUs are separate state government entities certified to investigate and prosecute health care providers suspected of defrauding the state's Medicaid program. MFCUs also have authority to review nursing home residents' neglect or abuse complaints and patient abuse complaints in other health care facilities receiving Medicaid payments. MFCUs may review complaints alleging misappropriation of patient funds. Subject to limitations, MFCUs are funded partially through a grant from OIG (75%) and partially with matching state funds (25%).

President's Proposal

This proposal would encourage territories to establish MFCUs by exempting federal support for MFCUs from the territories' Medicaid funding cap and by exempting territories from the

⁴² The five territories are American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

⁴³ Federal law now requires each state to have a MFCU unless the state can demonstrate to the satisfaction of the HHS Secretary that it has a minimum amount of Medicaid fraud and Medicaid beneficiaries will be protected from abuse and neglect. North Dakota has been granted a waiver and does not have a MFCU.

statutory ceiling on quarterly federal payments for the units. *This proposal was not included in the President's FY2014 Budget.*

Track High Prescribers and Utilizers of Prescription Drugs in Medicaid

Current Law

Medicaid statute gives states broad authority to implement a variety of prescription drug monitoring activities, though not all states have adopted such activities. A number of states have implemented voluntary or mandatory “lock-in” programs that require Medicaid beneficiaries who use prescription drugs at levels above certain medically necessary utilization guidelines, to obtain services only from designated providers, such as one pharmacy or a specific primary care provider. States also have linked Medicaid data with statewide prescription drug monitoring programs to help identify controlled substance abuse. In addition to Medicaid authority to impose restrictions, some states have passed laws to increase penalties on individuals who participate in diverting Medicaid drugs from medically necessary uses to drug abuse or fraudulent activities.

President's Proposal

The President's proposal would require states to monitor high risk Medicaid drug billing to identify and remediate prescribing and utilization patterns that could indicate potential abuse or excessive prescription drug utilization. States would have discretion to tailor their programs, for example, by choosing one or more drug classes subject to overuse or abuse, and states would be required to develop or review and update their high-utilization remediation plan. *This proposal was included in the President's FY2014 budget proposal.*

Consolidate Redundant Error Rate Measurement Programs

Current Law

The Improper Payments Information Act of 2002 (IPIA, P.L. 107-300) required federal agencies to annually review the programs they oversee that may be susceptible to erroneous payments, in order to estimate improper payments and report the estimates to Congress before March 31 of the following year. In addition, if estimated improper payments exceeded \$10 million per year, IPIA required federal agencies to identify ways to reduce erroneous payments. In response to IPIA, CMS implemented the Medicaid Payment Error Rate Measurement (PERM), which estimates improper Medicaid and CHIP payments. In addition to PERM, federal Medicaid law requires states to assess Medicaid eligibility and quality control (MEQC) by calculating and reporting erroneous Medicaid payment and eligibility determination rates. States have discretion to develop and implement their own MEQC methodologies. Under CMS PERM regulations, states now have the option to use PERM to fulfill the MEQC requirement.⁴⁴

President's Proposal

The President's budget would authorize the Secretary to consolidate the MEQC and PERM programs. *This proposal was included in the President's FY2014 budget proposal.*

⁴⁴ Centers for Medicare & Medicaid Services, “Medicaid Program and Children’s Health Insurance Program (CHIP); Revisions to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Programs,” 75 *Federal Register* 154, August 11, 2010.

Expand Medicaid Fraud Control Unit Review to Additional Care Settings

Current Law

MFCUs are separate state government entities certified to investigate and prosecute health care providers suspected of defrauding the state's Medicaid program. MFCUs also have authority to review nursing home residents' neglect or abuse complaints and patient abuse complaints in other health care facilities receiving Medicaid payments. MFCUs may review complaints alleging misappropriation of patient funds. MFCUs may not receive federal matching funds for patient abuse or neglect investigations that occur in non-institutional settings, such as home- and community-based services (HCBS). As more Medicaid long-term care services and supports have moved from institutional to non-institutional settings, there may be more need to monitor and investigate beneficiary complaints on non-institutional providers.

President's Proposal

The President's budget would allow MFCUs to receive federal matching funds for the investigation and prosecution of abuse and neglect in non-institutional settings, such as HCBS. *This proposal was included in the President's FY2014 budget proposal.*

Prevent Use of Federal Funds to Pay State Share of Medicaid or CHIP

Current Law

Medicaid and CHIP are both programs that are jointly funded by the federal government and states. Federal reimbursement for the federal share of the cost of Medicaid services is provided on an open-ended basis to states that meet federal program requirements. The federal government's share of most Medicaid expenditures is called the federal medical assistance percentage (FMAP) rate. However, exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, services, and administration. Federal CHIP matching funds are paid to states at an enhanced FMAP (E-FMAP) rate. The CHIP E-FMAP applies to both services and administration, but federal CHIP matching funds are capped based on annual allotments.⁴⁵ In general, federal regulations prohibit states from using other federal sources to fund the state share of Medicaid, unless authorized by law.

President's Proposal

The President's budget would codify the principle that states are prohibited from using federal funds to pay the state share of Medicaid or CHIP, unless specific exceptions were authorized in law. *This proposal was included in the President's FY2014 Budget.*

⁴⁵ For more information about CHIP, see CRS Report R40444, *State Children's Health Insurance Program (CHIP): A Brief Overview*, by Elicia J. Herz and Evelyn P. Baumrucker.

Medicare and Medicaid

Retain a Portion of RAC Recoveries to Implement Actions That Prevent Fraud and Abuse

Current Law

Recovery audit contractors (RACs) receive a percentage of any improper payments they recover. Congress initially authorized RACs as limited demonstrations for Medicare Parts A and B fee-for-service, but expanded the program nationally. Then, under the ACA, Congress authorized further RAC expansion to Medicare Parts C and D and Medicaid. Under current law, Medicare RAC recoupments, net of the percentage payments to contractors and other administrative expenses, are returned to the Medicare Trust Fund. Medicaid recoupments are returned to the state and federal government in the same proportion as FMAP rates with federal RAC recoveries deducted from the next federal Medicaid payment. CMS also can use RAC recoveries to administer the program, but is prohibited from using RAC recoveries to fund further corrective actions, such as new processing edits and provider education and training.

President's Proposal

The President's budget would authorize CMS to retain a portion of RAC recoveries from Medicare and Medicaid to fund corrective actions, such as new processing edits and provider education and training, to prevent future improper payments. *This proposal was included in the President's FY2014 Budget.*

Permit Exclusion from Federal Health Care Programs if Affiliated with Sanctioned Entities

Current Law

HHS OIG has authority to exclude health care providers (individuals and entities) from participation in federal health care programs. HHS OIG exclusion authority is mandatory in some circumstances and optional in others. The ACA extended HHS OIG authority to include individuals or entities that make false statements or misrepresentations on federal health care program enrollment applications, including explicit applicability to MA plans, PDPs, and these organization's providers and suppliers.

President's Proposal

The President's budget would expand HHS OIG authority to exclude individuals and entities from federal health programs if they are affiliated with sanctioned entities. The proposal would eliminate a loophole that allows the officers, managing employees, or owners of sanctioned entities to evade exclusion from federal health programs by resigning their positions or divesting their ownership interests. This proposal's exclusion authority also would be extended to entities affiliated with sanctioned entities. *This proposal was included in the President's FY2014 Budget.*

Strengthen Penalties for Illegal Distribution of Beneficiary Identification Numbers

Current Law

There are no specific penalties for selling, trading, bartering, or otherwise distributing beneficiary or identification numbers or billing privileges. Beneficiary identification numbers and provider/supplier billing privileges could be used to submit fraudulent claims to Medicare, Medicaid, or the CHIP programs.

President's Proposal

The President's budget proposal would strengthen penalties for knowingly distributing Medicare, Medicaid, or CHIP beneficiaries' identification or billing privileges. *This proposal was included in the President's FY2014 Budget.*

Table 4. Estimated Cost/Savings for Program Integrity Legislative Proposals Included in the President's FY2015 Budget Proposal

(dollars in millions)

		HHS Cost/Savings Estimates		
	New (N), Modified (M), or Repeated (R) from the President's FY2014 Budget	FY2015	FY2015-FY2019	FY2015-FY2024
Medicare				
Allow Prior Authorization for Medicare Fee-for-service Items	M	—	-\$40	-\$90
Allow Civil Monetary Penalties for Providers and Suppliers who Fail to Update Enrollment Records	R	—	-40	-90
Allow the Secretary to Create a System to Validate Practitioners' Orders for Certain High Risk Items and Services	R	—	—	—
Increase Scrutiny of Providers Using Higher-Risk Banking Arrangements to Receive Medicare Payments	R	—	—	—
Retain a Percentage of Incentive Reward Program Recoveries	N	—	—	—
Medicaid				
Support Medicaid Fraud Control Units for the Territories	N	I	5	10
Track High Prescribers and Utilizers of Prescription Drugs in Medicaid	R	-20	-240	-540
Consolidate Redundant Error Rate Measurement Programs	R	—	—	—
Expand Medicaid Fraud Control Unit Review to Additional Care Settings	R	—	—	—

	New (N), Modified (M), or Repeated (R) from the President's FY2014 Budget	HHS Cost/Savings Estimates		
		FY2015	FY2015-FY2019	FY2015-FY2024
Prevent Use of Federal Funds to Pay State Share of Medicaid or CHIP	R	—	—	—
Medicare and Medicaid				
Retain a Portion of RAC Recoveries to Implement Actions That Prevent Fraud and Abuse	R	—	-70	-250
Permit Exclusion from Federal Health Care Programs if Affiliated with Sanctioned Entities	R	—	-10	-60
Strengthen Penalties for Illegal Distribution of Beneficiary Identification Numbers	R	—	—	—
Total Program Integrity Savings from Legislative Proposals		-\$19	-\$395	-\$1,020

Source: Table created by CRS based on data from the Department of Health and Human Services, *Fiscal Year 2015 Budget in Brief: Strengthening Health and Opportunity for All Americans*, March 2014.

Notes: Totals may not add due to rounding.

CHIP: State Children's Health Insurance Program

HHS: Health and Human Services

RAC: Recovery audit contractors

CHIP Legislative Proposals

Extend the CHIP Performance Bonus Fund

Current Law

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) established performance bonus payments for states that increase their Medicaid (not CHIP) enrollment among low-income children above a defined baseline. To qualify for bonus payments, states have to implement five of eight outreach and enrollment activities and achieve state-specific targets for increasing Medicaid enrollment among children. CHIPRA performance bonus payments began in FY2009, and under current law, FY2013 was the final year a state can earn a bonus payment. From FY2009 through FY2013, 27 states received CHIPRA performance bonus payments totaling \$1.1 billion over the five years. Some states received payments in more than one year.

Funding for the CHIPRA performance bonus payments was provided through an initial one-time appropriation of \$3.2 billion in FY2009. In addition, funding for the bonus payments was transferred from unspent national appropriation amounts for FY2009 through FY2013 for CHIP allotments and unspent redistribution amounts. The fund balance for the CHIPRA performance bonus payments increased significantly every year because the unspent national allotment and redistribution amounts transferred into the fund were substantially higher than the actual CHIPRA

performance bonus payments to states. From FY2011 through FY2014, multiple appropriations laws have rescinded a total of \$22.6 billion in the funding for CHIPRA performance bonus payments. As of February 2014, the fund balance for the CHIPRA performance bonus funding was \$1.8 billion.

President's Proposal

The President's budget proposes to extend the CHIPRA performance bonus payments for one year, which would make states eligible for bonus payments in FY2014. The proposal would also change the programmatic requirements for states to qualify for the CHIPRA performance bonus payments. *This proposal was not included in the President's FY2014 Budget.*

**Table 5. Estimated Cost/Savings for CHIP Legislative Proposals
Included in the President's FY2015 Budget Proposal**

(dollars in millions)

	New (N), Modified (M), or Repeated (R) from the President's FY2014 Budget	HHS Cost/Savings Estimates		
		FY2015	FY2015-FY2019	FY2015-FY2024
Permanently Extend Express Lane Eligibility for Children ^a	N	\$10	\$135	\$345
Extend the CHIP Performance Bonus Fund	N	—	—	—
Total Changes in Outlays from Legislative Proposals		\$10	\$135	\$345

Source: Table created by CRS based on data from the Department of Health and Human Services, *Fiscal Year 2015 Budget in Brief: Strengthening Health and Opportunity for All Americans*, March 2014.

Notes: Totals may not add due to rounding.

CHIP: State Children's Health Insurance Program

HHS: Health and Human Services

- a. This proposals impact both Medicaid and CHIP. See the "Medicaid Coverage" section for descriptions of these legislative proposals. The President's FY2015 budget was released prior to the enactment of the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93), and PAMA impacts this legislative proposal. The cost and savings estimates in this table were calculated by the Administration prior to the enactment of PAMA. For detail about how PAMA impacts this proposal, see the description of the proposal above.

State Grants and Demonstrations Proposals

Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care (State Grants and Demonstrations Impact)

Current Law

Nearly all children in foster care are eligible for Medicaid and are generally entitled to the same set of Medicaid benefits as other children enrolled in Medicaid, including coverage for

psychotropic medications (i.e., prescribed drugs that affect the brain chemicals related to mood and behavior to treat a variety of mental health conditions). Certain factors—longer involvement with the child welfare agency, being of school age, and living in a group setting—forecast a greater chance that a child in foster care takes psychotropic medications. Little research has been conducted to show that psychotropics are effective and safe for children with mental health disorders. Federal child welfare law (Title IV-B, Subpart 1 of the Social Security Act) requires states to provide HHS with information about protocols they have in place for the appropriate use and monitoring of psychotropic medication.

President's Proposal

The President's budget proposes a five-year joint initiative between CMS and the Administration for Children and Families (ACF), which administers child welfare programs and activities, to provide performance-based incentive payments to states through Medicaid in order to reduce reliance on psychotropic medications for children in foster care by encouraging the use of evidence-based screening, assessment, and treatment of trauma and mental health disorders. ACF would receive separate funding to provide competitive grants for related purposes. *This proposal was not included in the President's FY2014 Budget.*

Medicaid Integrity Program Investment and Expanded Authority

Current Law

DRA required the Secretary to establish a Medicaid Integrity Program (MIP), which was the first dedicated appropriation providing dedicated Medicaid program integrity resources. Prior to MIP, program integrity was jointly funded by states and the federal government, but when state revenue declined during recessions, program integrity activities tended to decrease. MIP supports state Medicaid program integrity efforts through a combination of oversight and technical assistance. Although individual states work to ensure the integrity of their respective Medicaid programs, MIP provides CMS with resources to implement and monitor broader program integrity activities to support and enhance individual state efforts. DRA designated MIP funds to be used in the following four areas: audits, state support, data analysis, and education.

President's Proposal

This proposal would increase annual MIP appropriations by \$25 million (adjusted by CPI-U) and expand statutory authority for using MIP resources, such as funding an expansion of the Medicaid Financial Management program (currently funded under the HCFAC program) and technical assistance to states (including oversight of managed care entities, claims processing improvements, advanced fraud prevention analysis, and provider screening). *This proposal was not included in the President's FY2014 Budget.*

Extend and Improve the Money Follows the Person Demonstration

Current Law

Under the Money Follows the Person (MFP) Demonstration, the HHS is authorized to award competitive grants to states to transition institutionalized Medicaid enrollees into community residential settings with the goal of increasing the use of Medicaid home and community-based services. MFP was established under the DRA, and Section 2403 of the ACA extended the demonstration and appropriated an additional \$2.25 billion through FY2016. For each eligible

Medicaid enrollee who is transitioned into the community the state Medicaid program receives an increased federal matching rate for 12 months. Eligible Medicaid enrollees must be a resident in an institution for at least 90 consecutive days and continue to require the level of care provided in an institution. Medicare-covered days for short-term rehabilitative services are excluded from counting toward the 90-day period.

President's Proposal

The President's budget proposes to extend the MFP Demonstration through FY2020 within the existing appropriation. The proposal would authorize funds to be used to prevent individuals from entering an institution rather than only transitioning individuals from an institutional setting to a community-based setting. The proposal would also reduce the institutional requirement from 90 to 60 days and allow Medicare-covered days to count towards this requirement. Finally, it would allow individuals in certain mental health facilities to transition to community residential settings. *This proposal was not included in the President's FY2014 Budget.*

Table 6. Estimated Cost/Savings for State Grants and Demonstrations Legislative Proposals Included in the President's FY2015 Budget Proposal

(dollars in millions)

	New (N), Modified (M), or Repeated (R) from the President's FY2014 Budget	HHS Cost/Savings Estimates		
		FY2015	FY2015-FY2019	FY2015-FY2024
Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care ^a	N	—	\$390	\$500
Medicaid Integrity Program Investment and Expanded Authority ^b	N	25	131	276
Extend and Improve the Money Follows the Person Demonstration	N	—	—	—
Total Changes in Outlays from Legislative Proposals		\$25	\$521	\$776

Source: Table created by CRS based on data from the Department of Health and Human Services, *Fiscal Year 2015 Budget in Brief: Strengthening Health and Opportunity for All Americans*, March 2014.

Notes: Totals may not add due to rounding.

HHS: Health and Human Services

- a. This proposal impacts both Medicaid and the State Grants and Demonstrations. See "Medicaid Legislative Proposals" for the explanation of this proposal.
- b. The totals represent proposed budget authority for the Medicaid Integrity Program rather than outlays.

Private Health Insurance Programs Proposals

Accelerate Issuance of State Innovation Waivers

Current Law

Under Section 1332 of the ACA, a state may apply to the Secretaries of HHS and Treasury for waivers of certain ACA requirements with respect to health insurance coverage in that state for plan years beginning on or after January 1, 2017. A state may apply for a “state innovation waiver” for all or any of the following ACA requirements:

- Title I, subtitle D, Part I (relating to the establishment of qualified health plans);
- Title I, subtitle D, Part II (relating to consumer choice and insurance competition through health benefit exchanges);
- Section 1402 (relating to reduced cost sharing for individuals enrolling in qualified health plans);
- Section 36B of the Internal Revenue Code (relating to refundable tax credits for coverage under a qualified health plan offered through an exchange);
- 4980H of the Internal Revenue Code (relating to shared responsibility for employers regarding health coverage); and
- 5000A of the Internal Revenue Code (relating to the requirement to maintain minimum essential coverage).

The Secretaries have the authority to grant a request for one or more state innovation waivers if the Secretaries determine that the state has legislation in place that creates a system or plan that will provide health insurance coverage that is at least as comprehensive and affordable as coverage provided under the ACA; will provide that coverage to a comparable number of its residents as provisions of the ACA would provide; and will not increase the federal deficit.

President's Proposal

The President's budget would allow states to obtain state innovation waivers beginning in 2015, two years earlier than is currently permitted. *This proposal was included in the President's FY2014 budget proposal.* [The Administration estimates this legislative proposal would have no budgetary impact.]

Program Management Proposals

Provide Mandatory Administrative Resources for Implementation

Current Law

CMS's program management account funds the majority of Medicare's administrative and oversight functions, and program management activities include both discretionary and mandatory appropriations. Discretionary program management includes the following five account categories: program operations, federal administration, survey and certification, research, and state high-risk pools. The largest program management expenditure category is program operations, which funds a range of contractor and information technology activities necessary to

administer Medicare, Medicaid, CHIP, implementation of private health insurance programs, and additional activities required by legislation. Mandatory program management appropriations (\$199 million) were established by the following five laws: ACA, ARRA, MIPPA, ATRA, and BBA. In addition, the President's FY2015 budget for program management includes reimbursable administration (\$936 million) and provisions for new legislative initiatives (\$433 million).⁴⁶

President's Proposal

The President's budget would increase mandatory funding for Program Management by \$400 million to fund implementation of the mandatory health care proposals in the President's budget. *This proposal was included in the President's FY2014 budget proposal.*

Allow CMS to Reinvest Civil Monetary Penalties Recovered from Home Health Agencies

Current Law

Section 1891 of the Social Security Act requires HHAs participating in the Medicare program to comply with certain conditions of participation, such as quality of care and safety standards. To verify an HHA's compliance with Medicare's conditions of participation, CMS contracts with each state survey agency to conduct a recertification survey every three years. HHAs that are out of compliance can be cited for deficiencies and face intermediate sanctions, such as directed plans of correction and temporary management changes. Beginning July 1, 2014, intermediate sanctions for noncompliant HHAs will also include suspension of Medicare payments for new patient admissions and civil monetary penalties. Unless otherwise specified, Section 1128A of the Social Security Act requires such civil monetary penalties levied and collected in accordance with the Medicare program to be returned to the Medicare Trust Funds. However, Section 6111 of the ACA allows a portion of civil monetary penalties levied against noncompliant SNFs to be retained to support initiatives that improve the quality of SNF care.

President's Proposal

The President's budget would allow civil monetary penalties collected from HHAs to be retained and invested for activities to improve the quality of care of patients receiving home health services. *This proposal was not included in the President's FY2014 Budget.*

Assess Administrative Costs for the Federal Payment Levy Program

Current Law

Under current law, the Federal Payment Levy Program authorizes CMS to impose levies on Medicare providers for debts to the federal government. CMS and states electronically match Medicare provider payments with delinquent tax and non-tax debts and payments disbursed by

⁴⁶ Reimbursable administration is offsetting collections from non-federal sources that includes Health Insurance Exchanges, Clinical Laboratory Improvement Amendments of 1988, sale of research data, coordination of benefits for the Medicare prescription drug program, Medicare Advantage/prescription drug program education campaign, recovery audit contractors, and provider enrollment fees.

the federal government. The program allows the Department of the Treasury to assess a fee up to 15% of a provider's outstanding Medicare reimbursement as collateral against outstanding debts.

President's Proposal

The President's FY2015 budget would authorize CMS to assess a fee to offset the administrative costs of the Federal Payment Levy Program. The Department of the Treasury would continue to receive the full amount of the levy, and Medicare providers would be required to pay CMS fees to cover administrative costs for operating the Federal Payment Levy Program, which are estimated to be \$2 million in FY2015. *This proposal was not included in the President's FY2014 Budget.*

Enact Survey and Certification Revisit User Fees

Current Law

Federal and state governments share responsibility for ensuring that many Medicare and Medicaid providers and suppliers provide quality care and meet certain safety standards.⁴⁷ The federal government sets quality and safety requirements that these entities must meet to participate in the Medicare and Medicaid programs. In general, CMS contracts with organizations (often state survey agencies) to conduct periodic inspections and investigate quality or safety complaints. CMS estimated that in FY2014 survey and certification entities will complete over 24,434 initial surveys and re-certifications and investigate over 51,400 complaints.⁴⁸ All facility providers must undergo initial survey and certification inspections when they enroll as providers in Medicare or Medicaid, and be recertified on a regular basis thereafter. CMS intends to add inspection requirements for community mental health centers in FY2014. When surveyors identify deficiencies, surveyed entities have a certain period of time to correct the issues before surveyors revisit the facility to verify that the deficiencies were corrected.

President's Proposal

The President's budget proposes to require the Secretary to begin requiring user fees for survey and certification revisit. The revisit fee would provide CMS with additional resources to conduct follow up visits to poor performing providers, while also creating financial incentives for organizations to quickly correct deficiencies. The revisit fee would be phased in over a number of years. *This proposal was included in the President's FY2014 budget proposal.*

Extend Funding for CMS Quality Measurement Development

Current Law

Under current law, two provisions authorize specified quality and performance measurement duties for a contracted consensus-based entity. Section 183 of MIPPA requires the Secretary to have a contract with a consensus-based entity (e.g., National Quality Forum) to carry out specified performance improvement and quality measurement duties. These duties include,

⁴⁷ The Medicare and/or Medicaid programs, through state survey agencies, contractors, or other entities, surveys and certifies at least the following providers and suppliers: long-term care facilities, home health agencies, accredited and non-accredited hospitals, organ transplant facilities, dialysis facilities, ambulatory surgical centers, hospices, outpatient physical therapy, outpatient rehabilitation, rural health clinics, and portable X-Ray facilities.

⁴⁸ *Fiscal Year 2015 Budget in Brief, Strengthening Health and Opportunity for All Americans*, Department of Health and Human Services, March 2014.

among others, priority setting; measure endorsement; measure maintenance; convening multi-stakeholder groups to provide input on the selection of quality measures and national priorities; and annual reporting to Congress. Section 3014 of the ACA requires the Secretary to establish a pre-rulemaking process to select quality measures. This process involves gathering multi-stakeholder input; making measures under consideration available to the public; transmitting the input of multi-stakeholder groups to the Secretary; and publishing the rationale for the use of any quality measure in the Federal Register. The Secretary must also establish a process for disseminating quality measures used by the Secretary and to periodically review quality measures and determine whether to maintain them or phase them out. Under current law, funding expired for Section 183 of MIPPA in FY2013 and for Section 3014 of ACA in FY2014.

President's Proposal

The President's budget would extend funding for both quality and performance measurement duties by providing \$30 million per year, available until expended, for both Section 183 of MIPPA and Section 3014 of the ACA for each of the fiscal years FY2015 through FY2017. The allocation of funding between the two sections is not specified in the proposal. *This proposal is a modification of a legislative proposal from the President's FY2014 Budget.*⁴⁹

Table 7. Estimated Cost/Savings for Program Management Legislative Proposals Included in the President's FY2015 Budget Proposal

(dollars in millions)

		HHS Cost/Savings Estimates		
	New (N), Modified (M), or Repeated (R) from the President's FY2014 Budget	FY2015	FY2015-FY2019	FY2015-FY2024
Medicare Part A				
Provide Mandatory Administrative Resources for Implementation	R	\$25	\$400	\$400
Allow CMS to Reinvest Civil Monetary Penalties Recovered from Home Health Agencies	N	I	5	10
Assess Administrative Costs for the Federal Payment Levy Program	N	—	—	—
Enact Survey and Certification Revisit User Fees	M	—	—	—
Extend Funding for CMS Quality Measurement Development ^a	M	10	90	90

⁴⁹ The President's FY2015 budget was released prior to the passage of the Protecting Access to Medicare Act of 2014 (P.L. 113-93), which includes a provision extending funding for quality measure endorsement, input, and selection. For the remainder of FY2014 and FY 2015, funding for Section 183 of MIPPA and Section 3014 of ACA has been combined, with \$5 million being transferred from the Medicare Part A and Part B Trust Funds for FY2014 and \$15 million being transferred for the first six months only of FY2015 to carry out activities under these sections. Since PAMA extends funding for quality measurement through FY2015, the estimated savings for this provision would be smaller than the savings listed in **Table 7**.

New (N), Modified (M), or Repeated (R) from the President's FY2014 Budget	HHS Cost/Savings Estimates		
	FY2015	FY2015- FY2019	FY2015- FY2024
Total Changes in Outlays from Legislative Proposals	\$36	\$495	\$500

Source: Office of Budget and Management, Summary Table, S-9. Mandatory and Receipt Proposals.

Notes:

CMS: Centers for Medicare & Medicaid Services

HHS: Health and Human Services

- a. The President's FY2015 budget was released prior to the enactment of the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93), and PAMA impacts this legislative proposal. The cost and savings estimates in this table were calculated by the Administration prior to the enactment of PAMA. For detail about how PAMA impacts this proposal, see the description of the proposal above.

Author Information

Alison Mitchell, Coordinator
Analyst in Health Care Financing

Annie L. Mach
Analyst in Health Care Financing

Evelyne P. Baumrucker
Analyst in Health Care Financing

Paulette C. Morgan
Specialist in Health Care Financing

Cliff Binder
Analyst in Health Care Financing

William R. Morton
Analyst in Income Security

Andorra Bruno
Specialist in Immigration Policy

Amanda K. Sarata
Specialist in Health Policy

Kirsten J. Colello
Specialist in Health and Aging Policy

Carmen Solomon-Fears
Specialist in Social Policy

Patricia A. Davis
Specialist in Health Care Financing

Jennifer A. Staman
Legislative Attorney

Adrienne L. Fernandes-Alcantara
Specialist in Social Policy

Emilie Stoltzfus
Specialist in Social Policy

Jim Hahn
Specialist in Health Care Financing

Scott R. Talaga
Analyst in Health Care Financing

Judith A. Johnson
Specialist in Biomedical Policy

Susan Thaul
Specialist in Drug Safety and Effectiveness

Suzanne M. Kirchhoff
Analyst in Health Care Financing

Sibyl Tilson
Specialist in Health Care Financing

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